SENTARA COMMUNITY PLAN
(MEDICAID)

MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-844-305-2331**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed**.

Drug Requested: Rezzayo™ (rezafungin) **IV (J0349) (Medical)**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

Requested Medication is ONE of the following:

- ❑ New Start
- ❑ Continuation of therapy – provide therapy start date: _____

❑ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

Dosing Limits:

- ❑ **Quantity Limit (max daily dose) [NDC Unit]:**
  - 200 mg vial: 2 vials for loading dose, 4 vials to complete FOUR weekly maintenance doses = 1200 maximum billable units
  - NDC: 70842-0240-01
- ❑ **Max Units (per dose and over time) [HCPCS Unit]:**
  - 6 vials per treatment course

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CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Authorization Length: 12 months

- ❑ Member is 12 years of age or older
- ❑ Prescribed by or in consultation with an infectious disease specialist
- ❑ Provider has submitted documentation recording systemic signs of infections caused by candidemia or invasive candidiasis (e.g., fever, hypothermia, hypotension, tachycardia, or tachypnea)
- ❑ Provider has submitted documentation of mycological evidence from a blood sample or a normally sterile site showing a Candida species causing candidemia or invasive candidiasis
- ❑ Member does **NOT** have severe hepatic impairment with a history of chronic cirrhosis (Child-Pugh score > 9)
- ❑ Member does **NOT** have endocarditis, osteomyelitis, meningitis, septic arthritis, chorioretinitis, chronic disseminated candidiasis, or urinary tract infection due to a Candida species
- ❑ Member has a medication treatment history showing failure to **ONE** of the following along with documentation of clinical status demonstrating limited or no alternative options for the treatment of candidemia and invasive candidiasis:
  - ❑ Trial of **ONE** echinocandins (unless susceptibility panel documents resistance): caspofungin with a loading dose 70 mg, then 50 mg daily; micafungin given 100 mg daily; anidulafungin with a loading dose of 200 mg, then 100 mg daily for the appropriate length of therapy, or until progressing growth of Candida species observed
  - ❑ Fluconazole, intravenous or oral, 800 mg (12 mg/kg) loading dose, then 400 mg (6 mg/kg) daily for the appropriate length of therapy, or until progressing growth of Candida species observed

Medication being provided by: Please check applicable box below.

- ❑ **Location/site of drug administration:** _____

  NPI or DEA # of administering location: _____

  OR

- ❑ **Specialty Pharmacy**

For urgent reviews: Practitioner should call Sentara Health Plans Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara Health Plan's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****