SENTARA HEALTH PLANS

PHARMACY 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 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Non-Preferred Insulins

Drug Requested: Select one from below

Rapid-acting Insulin Products		
❑ **Admelog®** (insulin lispro) **vial/SoloStar®**	❑ **Apidra®** (insulin glulisine) **vial/SoloStar®**	❑ **Fiasp®** (insulin aspart) **vial/FlexTouch®/PenFill®/ PumpCart®**
❑ **Humalog® U-200** (insulin lispro) **KwikPen®**	❑ **insulin aspart vial/cartridge/pen** (Novolog ABA)	❑ **Kirsty™** (insulin aspart-xjhz) **vial/pen**
❑ **Lyumjev®** (insulin lispro-aabc) **vial/KwikPen®**	❑ **Merilog™** (insulin aspart-szjj) **vial/SoloStar®**	❑ **Novolog®** (insulin aspart) **vial/FlexPen®/PenFill®**
Regular or short-acting Insulin Products		
❑ **Novolin® R** (Regular, Human Insulin) **vial/FlexPen®**		
Intermediate-acting Insulin Products		
❑ **Novolin® N** (NPH, Human Insulin) **vial/FlexPen®**		
Long-acting Insulin Products		
❑ **Awiqli®** (insulin icodec-abae) **FlexTouch®**	❑ **Basaglar®** (insulin glargine) **KwikPen®**	❑ **insulin degludec vial/pen** (Tresiba ABA)
❑ **insulin glargine vial/ SoloStar®** (Lantus ABA)	❑ **insulin glargine SoloStar®/Max SoloStar®** (Toujeo SoloStar® ABA)	❑ **insulin glargine-yfgn** (mfg: Civica & Mylan)
❑ **Levemir®** (insulin detemir) **vial/FlexTouch®**	❑ **Semglee®** (insulin glargine-yfgn) **vial/pen**	❑ **Tresiba®** (insulin degludec) **vial/FlexTouch®**
Combination of Insulin Products:		
❑ **insulin aspart protamine suspension/insulin aspart mix 70/30 vial/FlexPen®** (Novolog Mix ABA)	❑ **Novolin® 70/30** (70% NPH, Human Insulin Isophane Suspension & 30% Regular, Human Insulin) **vial/FlexPen®**	❑ **Novolog® Mix 70/30** (70 % insulin aspart protamine suspension & 30% insulin aspart) **vial/FlexPen®**

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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: _____

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

❑ **For Novolin® Brand, Mix or ABA products, the following criteria must be met:**

- ❑ Member has tried and failed at least **30 days** of therapy with a Humulin® product

❑ **For Admelog®, Apidra®, Fiasp®, Humalog® U-200 KwikPen®, insulin aspart, Kirsty™, Lyumjev®, Merilog™ and Novolog® Brand, Mix or ABA products, all the following criteria must be met:**

- ❑ Member must have a **30-day trial** and failure or intolerance to brand Humalog® U-100
- ❑ Provider must submit clinical chart notes or a completed MedWatch form documenting the experienced treatment failure or intolerance to brand Humalog® U-100

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- ❑ **For Awiqli®, Basaglar®, insulin degludec, insulin glargine, Levemir®, Semglee® Brand or ABA products and Tresiba®, the following criteria must be met:**
  - ❑ Member has tried and failed at least **30 days** of therapy with **ONE** of the following
    - ❑ insulin glargine-yfgn (mfg: Biocon)
    - ❑ Lantus®
    - ❑ Toujeo®

Not all drugs may be covered under every Plan.

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****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.****

***Approved by the Pharmacy and Therapeutics Committee**: ~~10/15/2015; 9/21/2023; 7/24/2025; 9/25/2025;~~ **9/24/2026**
REVISED/UPDATED/REFORMATTED: ~~10/26/2015; 12/22/2015; 6/16/2016; 8/3/2016; 12/12/2016; 5/4/2017; 5/17/2017; 6/28/2017; 8/14/2017; 6/29/2018; 10/19/2018;6/18/2019; 8/12/2019; 6/11/2020; 12/22/2020; 12/5/2023; 1/22/2024; 8/18/2025; 10/23/2025, 12/22/2025; 3/6/2026;~~ **10/15/2026**