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: Sustol® (granisetron extended-release injection) **(J1627) (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:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

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

Weight: _____ **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.

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.

Initial Authorization: 6 months

❑ Member is 18 years of age or older

❑ Prescribed by or in consultation with an oncology specialist

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- ❑ Member must meet **ONE** of the following:
  - ❑ Member is receiving highly emetogenic chemotherapy (HEC) [e.g., any chemotherapy regimen that contains an anthracycline and cyclophosphamide; additionally, agents such as carboplatin with AUC ≥ 4, carmustine with dose > 250 mg/m^2, cisplatin, dacarbazine, doxorubicin with dose ≥ 60 mg/m^2, epirubicin with dose ≥ 90 mg/m^2]
  - ❑ Member is on moderate-low risk emetogenic chemotherapy **AND** has failed palonosetron (Aloxi®) while receiving the current chemotherapy regimen **(failure is defined as two or more documented episodes of vomiting)**
- ❑ Requested therapy will be administered subcutaneously by a healthcare provider on Day 1 of chemotherapy but **NOT** more frequently than once every 7 days
- ❑ Medication will **NOT** be prescribed for breathrough emesis or repeat dosing in multi-day emetogenic chemotherapy regimens

Reauthorization: 12 months. 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.

- ❑ Member continues to meet all initial authorization criteria

Medication being provided by (check applicable box(es) below):

❑ **Physician's office** **OR** ❑ **Specialty Pharmacy – PropriumRx**

For urgent reviews: Practitioner should call Sentara Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara'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.****