

# 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.**

**Drug Requested:** Xenleta™ (lefamulin)

**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: \_\_\_\_\_

**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.

- The patient has a diagnosis for Community-Acquired Bacterial Pneumonia

**FOR OUTPATIENT TREATMENT:** Chart notes, medication orders/history need to accompany this request. All will be verified through Pharmacy Claims

- The patient has tried and failed the following therapies:
- amoxicillin
  - AND**
  - doxycycline
  - AND**
  - macrolide antibiotic (azithromycin or clarithromycin)

**OR**

(Continued on next page)

- ❑ **FOR PATIENTS WITH COMORBIDITIES** (such as chronic heart, lung, liver or renal disease, diabetes mellitus, alcoholism, malignancy or asplenia) the following therapies have been tried:
  - ❑ Combination therapy with amoxicillin/clavulanate or cephalosporin (cefepodoxime or cefuroxime) AND a macrolide antibiotic or doxycycline

**AND**

- ❑ Monotherapy with a respiratory fluoroquinolone (levofloxacin, moxifloxacin, gemifloxacin)
  - ❑ Document any intolerabilities/contraindications/resistance to the above therapies (include medical documentation):
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**IF TREATMENT WAS STARTED IN AN INPATIENT SETTING:** Chart notes, medication orders/history need to accompany this request. All will be verified through Pharmacy Claims

- ❑ The patient has tried and failed the following therapies:
    - ❑ Beta-lactam antibiotic (ampicillin/sulfabactam, cefotaxime, ceftriaxone) PLUS a macrolide antibiotic
- AND**
- ❑ Monotherapy with a respiratory fluoroquinolone
- AND**
- ❑ Beta-lactam antibiotic PLUS doxycycline
- ❑ Document any intolerabilities/contraindications/resistance to the above therapies (include medical documentation):
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*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.\**