SENTARA COMMUNITY PLAN
(MEDICAID)

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: Baxfendy™ (baxdrostat)

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:** _____

Recommended Dosing: Oral: 2 mg once daily. Patients at increased risk of hyperkalemia or hyponatremia: Oral: 1 mg once daily.

Quantity Limit: 1 tablet per day

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: 12 months

- ❑ Member is 18 years of age or older

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- ❑ Member is currently receiving treatment at maximum or maximally tolerated doses with at least **ONE** agent from each of the classes below, unless contraindicated, for the past 4 weeks **(verified by pharmacy paid claims; documentation of intolerances or contraindications must be submitted; check all that apply)**
  - ❑ Renin-angiotensin system (RAS) inhibitors (e.g., lisinopril, enalapril, losartan, valsartan)
  - ❑ Calcium channel blockers (e.g., amlodipine, felodipine, nifedipine, verapamil)
  - ❑ Thiazide/thiazide-like diuretics (e.g., hydrochlorothiazide, chlorthalidone, indapamide)
- ❑ Treatment with a mineralocorticoid receptor antagonist (spironolactone, eplerenone) has been added to the existing antihypertensive regimen and was ineffective, intolerable, or is contraindicated **(verified by pharmacy paid claims; documentation of intolerance or contraindication must be submitted)**
- ❑ Treatment with an additional antihypertensive agent with a different mechanism of action (e.g., hydralazine, minoxidil, clonidine, prazosin, metoprolol) has been ineffective, or are all contraindicated **(verified by pharmacy paid claims; documentation of intolerance or contraindication must be submitted)**
- ❑ Member has resistant hypertension as demonstrated by blood pressure ≥ 130/80 mmHg despite adherence to the prescribed antihypertensive drug regimen **(submit documentation of blood pressure reading recorded within 30 days of request)**
- ❑ Member has been adherent to prescribed antihypertensive drug regimen for at least 4 weeks prior to the date of the blood pressure reading recorded in chart note documentation **(adherence will be verified by pharmacy paid claims)**
- ❑ Provider has evaluated the member for causes of pseudoresistance (e.g., inaccurate blood pressure readings, white coat hypertension, secondary hypertension, non-adherence to medication) and confirms that pseudo-resistant hypertension has been ruled out
- ❑ Member will **NOT** use Baxfendy concomitantly with any of the following other medications: mineralocorticoid receptor antagonists, non-steroidal mineralocorticoid receptor antagonists, potassium-sparing diuretics, direct renin inhibitors, or aprocitentan
- ❑ Provider attests baseline serum potassium and serum sodium have been obtained and will be monitored periodically or as clinically indicated

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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's blood pressure has reduced from baseline after initiating therapy with Baxfendy™ **(submit documentation)**
- ❑ Member is adherent to Baxfendy™ and continues to receive Baxfendy™ in addition to background antihypertensive drug therapy **(verified by pharmacy paid claims)**
- ❑ Provider attests serum potassium and serum sodium continue to be monitored

Medication being provided by Specialty Pharmacy – Proprium Rx

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.*

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***Approved by Pharmacy and Therapeutics Committee**: 7/23/2026
REVISED/UPDATED/REFORMATTED: 8/27/2026