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.**

Topical Immunomodulators

Drug Requested (select below drug that applies):

❑ **Zyclara**® (imiquimod) **2.5% Pump**	❑ **Veregen**® (sinecatechins) **Ointment**
❑ **Zyclara**® (imiquimod) **3.75% Packets/Pump**	❑ **Solaraze**® (diclofenac) **3% Gel**

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.

❑ **Diagnosis - Actinic Keratosis (both boxes must be checked):**

- ❑ Member has diagnosis of actinic keratosis

(Continued on next page)

- ❑ Requested product:
  - ❑ Zyclara® 2.5% Pump
  - ❑ Zyclara® 3.75% Packets/Pump
  - ❑ Solaraze® 3% Gel

- ❑ **Diagnosis – External Genital and Perianal Warts/Condyloma Acuminata (two boxes must be checked)**

- ❑ Member has diagnosis of external genital and/or perianal warts/condylomata acuminata

AND

- ❑ Member has a documented trial and inadequate response or clinically significant adverse reaction to generic Aldara™ 5% cream **(submit chart notes)**

OR

- ❑ Member has a documented trial and inadequate response or clinically significant adverse reaction to topical podofilox **(submit chart notes)**

*****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.****

REVISED/UPDATED/REFORMATTED: ~~8/27/2017~~; ~~8/31/2018~~; ~~12/24/2019~~ **11/15/2023**