

# 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. **Incomplete forms will delay the authorization process.**

**Drug Requested:**                      **Pancreatic Enzymes (Non-Preferred Pancrelipase)**

**DRUGS:** Check box(es) below that apply. If not checked, authorization process will be delayed.

<input type="checkbox"/> <b>Pancreaze</b> <sup>®</sup>	<input type="checkbox"/> <b>Pertzye</b> <sup>®</sup>	<input type="checkbox"/> <b>Viokace</b> <sup>®</sup>
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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: \_\_\_\_\_

DEA OR NPI #: \_\_\_\_\_

**DRUG INFORMATION:** Complete information below or authorization will be delayed.

Drug Name/Form: \_\_\_\_\_ Strength: \_\_\_\_\_

Dosing Schedule: \_\_\_\_\_ Length of Therapy: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD Code, if applicable: \_\_\_\_\_

**CLINICAL CRITERIA:** Check box for applicable diagnosis or authorization process will be delayed.

- Trial and failure of **BOTH** of the following **PREFERRED** pancrelipases below:

<input type="checkbox"/> Creon <sup>®</sup>	<input type="checkbox"/> Zenpep <sup>®</sup>
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**\*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.\***