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 may be delayed.**

Drug Requested: (Select **ONE** drug below)

❑ **Posaconazole** (generic Noxafil®) **delayed-release tablets 100 mg**	❑ **Posaconazole** (generic Noxafil®) **immediate-release oral suspension 40 mg/mL**	❑ **Noxafil® PowderMix Pak** (posaconazole) **delayed-release oral suspension 300 mg**

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 Form/Strength: _____

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

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

Weight (if applicable): _____ **Date weight obtained:** _____

Quantity Limits:

- **Delayed-release tablets, 100 mg: 8 tablets per day**
- **Immediate- release oral suspension, 40 mg/mL: 20 mL per day**
- **Delayed- release oral suspension, 300 mg packets: 1 packet 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.

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IF REQUESTING AN ORAL SUSPENSION FORMULATION, please provide clinical-based reasoning and attach applicable documentation why the member cannot swallow tablets:

_____

_____

_____

_____

❑ Diagnosis: Aspergillosis

Approval Length: one time authorization, treatment period 6-12 weeks

- ❑ Member is 13 years of age or older
- ❑ Member has a diagnosis of invasive aspergillosis
- ❑ Member has a documented trial and failure, contraindication, or documented resistance to itraconazole or voriconazole therapy as first line therapy

❑ Diagnosis: Candidiasis Infection

Approval Length: one time authorization, treatment period up to 28 days

- ❑ Member is 13 years of age or older
- ❑ Member has **oropharyngeal** candidiasis, **AND** has documented trial and failure, contraindication, or documented resistance to clotrimazole troches, nystatin suspension, **AND** fluconazole
- ❑ Member has **esophageal** candidiasis refractory to fluconazole infection, **AND** has documented trial and failure, contraindication, or documented resistance to itraconazole **AND** voriconazole

❑ Diagnosis: Immunocompromised Patients, Prophylaxis against invasive fungal infections

Approval Length: 6 months

- ❑ Member is severely immunocompromised and treatment is required for prophylaxis of invasive aspergillus and Candida infections:
  - ❑ Allogeneic hematopoietic stem cell transplant [HSCT] recipient
  - ❑ Hematologic malignancy (i.e., Leukemia, lymphoma, myelodysplastic syndrome)
  - ❑ Prolonged neutropenia from chemotherapy
  - ❑ High-risk solid organ (lung, heart-lung, liver, pancreas, small bowel) transplant patient
- ❑ Member meets **ONE** of the following age/formulation criteria:
  - ❑ Delayed-release tablets (members ≥ 2 years of age and > 40 kg)
  - ❑ Immediate-release oral suspension (members ≥13 years of age)
  - ❑ Delayed-release oral suspension, powder mix (members ≥ 2 to <18 years of age and ≤ 40kg)

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❑ Diagnosis: Coccidioidomycosis

Approval Length: 6 months

- ❑ Member has a diagnosis of chronic coccidioidal pneumonia and meets the following:
  - ❑ Is symptomatic **[must provide progress notes, any laboratory documentation or imaging studies to convey debilitating illness and/or extensive pulmonary involvement with concurrent diabetes, and/or with age or comorbidity concern]**
  - ❑ Member has a documented trial and failure, contraindication, or documented resistance to itraconazole or fluconazole as first line therapy
- ❑ For members with subsequent HIV infection and clinical evidence of coccidioidomycosis: laboratory documentation of peripheral blood CD4+ T-lymphocyte count <250cells/µL must be submitted

  NOTE: IDSA 2016 – for patients with peripheral CD4+ T-lymphocyte counts ≥250 cells/µL, clinical management of coccidioidomycosis should occur in the same manner as for patients without HIV infection, including discontinuing antifungal therapy in appropriate situations.

❑ Diagnosis: Mucormycosis

Approval Length: 6 month

- ❑ Therapy is being used as salvage therapy for the treatment of mucormycosis
- ❑ Posaconazole is being used as step-down treatment from primary antifungal therapy

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.****