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.**

Macrolides & Ketolides (Oral)

Drug Requested: Check box below that applies.

PREFERRED	
❑ azithromycin pack/susp/tab	❑ clarithromycin tab/susp
❑ erythromycin ethylsuccinate 200mg susp	❑ erythromycin base tab DR
❑ erythromycin stearate	❑

NON-PREFERRED		
❑ Biaxin® tab	❑ clarithromycin ER	❑ Eryped® 200 & 400 susp
❑ Ery-tab®	❑ E.E.S.® 400 tab ❑ E.E.S. 200 susp	❑ Erythrocin® Stearate
❑ erythromycin base tab	❑ erythromycin base cap DR	❑ erythromycin ethylsuccinate 400 mg tab (generic E.E. S.® 400)
❑ PCE®	❑ Zithromax® pac/tab/susp	❑ ZMAX® susp

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 #: _____

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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:** _____

CLINICAL CRITERIA (for Non-Preferred): 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.

- ❑ Infection caused by an organism resistant to preferred drugs

OR

- ❑ A therapeutic failure to no less than a **three-day trial of ONE (1) PREFERRED drug within the same class**

OR

- ❑ Member is completing a course of therapy with a **non-preferred drug** which was initiated in the hospital.

*****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:** ~~6/29/2017; 8/31/2017; 8/27/2018; 3/13/2019; 6/13/2019;11/9/2023, 5/29/2024; 6/6/2024;~~ **6/17/2026**