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**	❑ **E.E.S.® 200 susp**
❑ **Eryped® 200 susp**	❑ **erythromycin base cap DR**	❑ **erythromycin stearate**

NON-PREFERRED			
❑ **Biaxin® tab**	❑ **clarithromycin ER**	❑ **Eryped® 400 susp**	❑ **Ery-tab®**
❑ **E.E.S.® 400 tab**	❑ **Erythrocin® Stearate**	❑ **erythromycin base tab**	❑ **erythromycin ethylsuccinate 400 mg tab** (generic E.E. S.® 400)
❑ **erythromycin ethylsuccinate 200 mg susp**	❑ **Ketek®**	❑ **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:** _____

DEA OR NPI #: _____

(Continued on next page)

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 (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.

CLINICAL CRITERIA for Ketek®. 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.

- ❑ Treatment of community-acquired pneumonia (of mild to moderate severity)

AND

- ❑ Infection is caused by **ONE** of the following microorganism:
  - ❑ Streptococcus pneumonia **OR**
  - ❑ Haemophilus influenza **OR**
  - ❑ Moraxella catarrhalis **OR**
  - ❑ Chlamydophila pneumonia **OR**
  - ❑ Mycoplasma pneumonia

AND

- ❑ Therapeutic failure to no less than a **three (3) day trial of ONE (1) Preferred** drug within the same class;

OR

- ❑ Member is completing a course of therapy with a **non-preferred** drug 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:** ~~6/29/2017~~; ~~8/31/2017~~; ~~8/27/2018~~; ~~3/13/2019~~; ~~6/13/2019~~ **11/9/2023**