

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.**

Drug Requested: (check box below that applies)

Lynkuet[®] (elinzanetant)

Veozah[®] (fezolinetant)

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 Name/Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

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

Recommended Dosage: One Tablet Daily

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.

1. Is the member 18 years of age or older? Yes No
2. Does the member have a diagnosis of menopause with moderate to severe vasomotor symptoms? Yes No
3. Has the member had a trial and failure, or is not a candidate for hormone therapy? Yes No

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4. Does the member have cirrhosis? Yes No
5. Does the member have severe renal impairment or end-stage renal disease? Yes No
6. Will the member avoid concomitant therapy with weak, moderate, or strong CYP1A2 inhibitors (e.g., fluvoxamine, mexiletine, cimetidine)? Yes No
7. Does the prescriber attest that baseline liver function tests have been conducted and total bilirubin, alanine aminotransferase (ALT), and aspartate aminotransferase (AST) levels are not elevated ≥ 2 times the upper limit of normal (ULN)? Yes No
8. Does the prescriber attest that liver function testing follow-up will be conducted as outlined in prescribing information? Yes No

*****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.****