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.**

The Sentara Health Plans Oncology Program is administered by OncoHealth

- **For any oncology indications,** the most efficient way to submit a prior authorization request is through the **OncoHealth OneUM Provider Portal** at https://oneum.oncohealth.us**. Fax to 1-800-264-6128.**

OncoHealth can also be contacted at Phone: 1-888-916-2616

Drug Requested: Jylamvo® (methotrexate) oral solution **(Non-Preferred)**

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:** _____

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Indication:	**Dosage:**
Treatment of adult and pediatric patients with acute lymphoblastic leukemia (ALL) as a component of a combination chemotherapy maintenance regimen	ALL: 20 mg/m2 once weekly
Treatment of pediatric patients with polyarticular juvenile idiopathic arthritis (pJIA)	Starting dose of 10 mg/m^2 one time weekly and adjust to optimal response
Treatment of adults with mycosis fungoides	25-75mg once weekly (monotherapy), or 10mg/m^2 twice weekly as combination therapy
Treatment adults with relapsed or refractory non-Hodgkin lymphoma as part of a metronomic combination regimen	2.5mg two to four times weekly
Treatment of adults with rheumatoid arthritis	Start at 7.5mg once weekly and adjust to optimal response
Treatment of adults with severe psoriasis	10-25mg once weekly

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.

- ❑ Patient has tried and failed **one** of the following:
  - ❑ Methotrexate solution for injection
  - ❑ Methotrexate tablets

Medication being provided by Specialty Pharmacy - PropriumRx

*****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.****