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: Cardamyst™ (etripamil)

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: Initial: One spray (35 mg) into each nostril using one device (total dose of 70 mg); may repeat after 10 minutes with a second device; if symptoms do not improve within 20 minutes of second dose, seek medical assistance. Maximum dose: 140 mg/day.

Quantity Limit: 2 cartons (4 nasal sprays) per 30 days

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.

Initial Authorization: 12 months

- ❑ Member is 18 years of age or older
- ❑ Prescribed by or in consultation with a cardiologist or electrophysiologist
- ❑ Member has a diagnosis of PSVT confirmed by electrocardiogram (ECG)
- ❑ Member has a history of sustained, symptomatic episodes of PSVT (i.e., typically lasting approximately 20 minutes or longer)

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- ❑ Member must meet **ONE** of the following:
  - ❑ Member has experienced at least one episode of PSVT that required hospitalization or visit to an emergency department/urgent care within the last 12 months
  - ❑ Member is currently receiving oral pharmacologic therapy for prevention of PSVT episodes (e.g., diltiazem, verapamil, metoprolol, atenolol, propranolol, nadolol, flecainide, propafenone)
- ❑ If member is currently receiving oral pharmacologic therapy for prevention of PSVT episodes, Cardamyst is prescribed concurrently with ongoing oral pharmacologic therapy for prevention
- ❑ Provider attests that catheter ablation has been considered but is not appropriate for the member at this time
- ❑ At the time of request, provider attests member has none of the following contraindications:
  - Wolff-Parkinson-White syndrome
  - Lown-Ganong-Levine syndrome
  - Manifest pre-excitation (delta wave) on a 12-lead ECG
  - Second degree atrioventricular (AV) Mobitz 2 block or higher degree of AV block
  - New York Heart Association (NYHA) Class II to IV heart failure
  - Sick sinus syndrome without a permanent pacemaker
- ❑ Requested quantity does **NOT** exceed 4 nasal spray devices per month
- ❑ Request dose does **NOT** exceed **BOTH** of the following in a 24-hour period
  - 140 mg
  - 2 nasal spray devices

Reauthorization: 12 months. 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.

- ❑ Member must meet **ONE** of the following:
  - ❑ Member was previously approved for the requested medication by Sentara Health Plans
  - ❑ Member meets all initial authorization criteria above
- ❑ Member is responding positively to therapy
- ❑ If member was previously receiving oral pharmacologic therapy for prevention of PSVT episodes, Cardamyst isprescribed concurrently with ongoing oral pharmacologic therapy for prevention
- ❑ Requested quantity does **NOT** exceed 4 nasal spray devices per month
- ❑ Request dose does **NOT** exceed **BOTH** of the following in a 24-hour period
  - 140 mg
  - 2 nasal spray devices

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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.****

***Approved by Pharmacy and Therapeutics Committee: 5/28/2026**
REVISED/UPDATED/REFORMATTED: 6/15/2026