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: Rhapsido® (remibrutinib)

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: 25 mg orally twice daily

Quantity Limit: 2 tablets per day

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

- ❑ Prescribed by or in consultation with a specialist in the area of the member's diagnosis (e.g., dermatologist, allergist, immunologist)
- ❑ Member is ≥ 18 years of age
- ❑ Member has had a confirmed diagnosis of chronic spontaneous urticaria, characterized by persistent hives and itching, for at least 6 weeks with or without angioedema

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- ❑ Member will continue second-generation H1-antihistamine therapy in combination with Rhapsido, unless a documented contraindication, hypersensitivity, or intolerance to the antihistamine
- ❑ Member does **NOT** have e mild, moderate, or severe hepatic impairment (Child-Pugh Class A, B or C)

❑ **Diagnosis: Chronic Spontaneous Urticaria**
Reauthorization: 12 months

- ❑ Members continues to meet the initial criteria
- ❑ Member continues to experience clinical benefit from the requested treatment

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.*

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***Approved by Pharmacy and Therapeutics Committee**: 11/20/2025
REVISED/UPDATED/REFORMATTED: ~~12/12/2025;~~ **6/26/2026**