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: Hyftor™ (sirolimus topical gel)

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 #: _____

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: 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 Approval: 12 months

1. Is the member 6 years of age or older? ❑ Yes ❑ No

AND

2. Does the member have a documented diagnosis of facial angiofibroma associated with tuberous sclerosis? ❑ Yes ❑ No

AND

3. Will live vaccines be avoided during treatment and will all age-appropriate vaccinations be completed before starting therapy? ❑ Yes ❑ No

(Continued on next page)

AND

4. Have individuals of reproductive potential been counseled to use effective contraception before and during treatment, as well as for 12 weeks after the last dose? ❑ Yes ❑ No

AND

5. Has the prescriber counseled the member on possible adverse effects (e.g., hypersensitivity reactions, serious infections, lymphoma and other malignancies, interstitial lung disease/non-infectious pneumonitis), including counseling male members that Hyftor may impair fertility?

❑ Yes ❑ No

AND

6. Will the member be monitored for adverse reactions if therapy is used concurrently with:
   - Inhibitors of CYP3A4 (e.g., clarithromycin, ketoconazole, nefazodone), due to the potential for increased sirolimus systemic exposure;

     AND
   - Drugs that are both substrates and inhibitors of CYP3A (e.g., aprepitant and tipranavir), due to the potential for increased systemic exposure of these concurrently administered agents?

❑ Yes ❑ No

Reauthorization Approval: 1 year. All criteria must be checked for approval. To support each line checked, all documentation (lab results, diagnostics, and/or chart notes) must be provided or request may be denied.

7. Does the member continue to meet the above criteria? ❑ Yes ❑ No

AND

8. Does the member have disease improvement or stabilization OR improvement in the slope of decline of the size and redness of the facial angiofibroma? ❑ Yes ❑ No

AND

9. Has the member experienced any treatment-restricting adverse effects (e.g., hypersensitivity reactions, serious infections, lymphoma and other malignancies, interstitial lung disease/non-infectious pneumonitis)? ❑ 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.****