SENTARA HEALTH PLANS

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 information provided is not complete, correct, or legible, authorization may be delayed.**

Drug Requested: (choose one below)

PREFERRED	
❑ **Depen®** (penicillamine) **Titratable tablets**	❑ **penicillamine tablets**
NON-PREFERRED	
❑ **Cuprimine®** (penicillamine)	❑ **penicillamine capsules**

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.

DIAGNOSIS: Check the diagnosis below that applies.

❑ **Diagnosis: Wilson's Disease**

Initial authorization: 6 months.

- ❑ Member **must** have diagnosis of Wilson's disease; **AND**
- ❑ Medication **must** be prescribed by or in consultation with a gastroenterologist or hepatologist; **AND**

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- ❑ Diagnosis was confirmed by **one (1)** of the following **(submit labs or chart notes for documentation):**
  - ❑ Presence of Kayser-Fleisher rings
  - ❑ Serum ceruloplasmin (CPN) <20mg/dL
  - ❑ 24-hour urine copper > 40 mcg
  - ❑ Liver biopsy with copper dry weight > 250 mcg/g

AND

- ❑ For Cuprimine® (penicillamine) capsule approval: Member has had trial and intolerable life-endangering adverse event with penicillamine tablets or Depen Titratable tablets **(must submit completed MedWatch form and chart notes to document adverse event)**; **AND**
- ❑ Dose will not exceed 1.5gm/day

❑ **Reauthorization approval for Wilson's Disease: 12 months**

- ❑ Member's serum copper level is <10 mcg free copper/dL of serum OR urinary copper excretion is maintained at 200-500 mcg (3-8 micromoles) per day on 24-hour urinary copper **assessment (submit current lab level for documentation)**; **AND**
- ❑ Dose will not exceed 1.5gm/day

❑ **Diagnosis: Cystinuria**

Initial authorization: 6 months.

- ❑ Member **must** have diagnosis of cystinuria; **AND**
- ❑ Medication **must** be prescribed by or in consultation with a nephrologist or metabolic geneticist; **AND**
- ❑ Member must have urinary cystine excretion of >300mg/day; **AND**
- ❑ Member must have had 30-day trial and failure of potassium citrate or other urinary alkalinizing agent along with sodium and protein-restricted diet and hyperdiuresis **(urine output of at least 3L/day)**; **AND**
- ❑ For Cuprimine® (penicillamine) capsule approval: Member has had trial and intolerable life-endangering adverse event with penicillamine tablets or Depen Titratable tablets **(must submit completed MedWatch form and chart notes to document adverse event)**; **AND**
- ❑ Dose will not exceed 4gm/day

❑ **Reauthorization for approval for Cystinuria: 12 months.**

- ❑ Member must have urinary cystine excretion of <200mg/day; **AND**
- ❑ Dose will not exceed 4gm/day

❑ **Diagnosis: Severe Active Rheumatoid Arthritis**

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Initial authorization: 6 months.

- ❑ Member must have a diagnosis of severe active rheumatoid arthritis; **AND**
- ❑ Medication **must** be prescribed by or in consultation with a rheumatologist; **AND**
- ❑ Member has had 30-day trial and failure of two (2) of the following: Humira®, Cimzia® or Simponi®; **AND**
- ❑ For Cuprimine® (penicillamine) capsule approval: Member has had trial and intolerable life-endangering adverse event with penicillamine tablets or Depen Titratable tablets **(must submit completed MedWatch form and chart notes to document adverse event)**; **AND**
- ❑ Dose will not exceed 250mg/day for the first month and 1.5gm/day for maintenance therapy

❑ **Reauthorization for Severe Active Rheumatoid Arthritis: 6 months**

- ❑ Member must have shown a clinically significant improvement in rheumatoid arthritis symptoms with chart notes documenting improvement in symptoms; **AND**
- ❑ Dose will not exceed 1.5gm/day for maintenance therapy

Medication being provided by Specialty Pharmacy - PropriumRx

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 pha rmacy paid claims or submitted chart notes.****