SENTARA COMMUNITY PLAN
(MEDICAID)

MEDICAL 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 1-844-305-2331**. 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 can be delayed**.

Drug Requested: Contepo™ (fosfomycin) **(J3490/C9399) (Medical)**

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:** _____

Requested Medication is ONE of the following:

- ❑ New Start
- ❑ Continuation of therapy – provide therapy start date: _____

❑ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

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.

❑ **New Start**

Length of Authorization: Date of Service (14 days)

- ❑ Member is 18 years of age or older

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- ❑ Prescribed by or in consultation with an infectious disease specialist, an antibiotic stewardship program, or protocol
- ❑ Member has a diagnosis of complicated urinary tract infection (cUTI) or pyelonephritis
- ❑ Provider has submitted lab cultures from current hospital admission or office visit collected within the last 7 days
- ❑ Lab cultures must show that bacteria is sensitive to Contepo
- ❑ Member must meet **ONE** of the following:
  - ❑ Provider must submit chart notes documenting trial and failure of **ALL** the following IV antibiotics: fluoroquinolones (levofloxacin or ciprofloxacin), third or fourth-generation cephalosporins (ceftriaxone, ceftazidime, cefotaxime, or cefepime), piperacillin-tazobactam, trimethoprim-sulfamethoxazole, gentamicin, tobramycin, amikacin, ertapenem, imipenem-cilastatin, and meropenem
  - ❑ Cultures (retrieved from most recent office visit or current inpatient admission collected within the last 7 days) shows resistance to **ALL** the following IV antibiotics: ciprofloxacin, levofloxacin, ceftriaxone, cefazolin, cefepime, piperacillin-tazobactam, trimethoprim-sulfamethoxazole, gentamicin, tobramycin, amikacin, ertapenem, imipenem-cilastatin, meropenem
- ❑ Member does **NOT** have heart or kidney failure along with signs and symptoms of edema, particularly in patients with cardiac insufficiency, renal impairment, cirrhosis, hyperaldosteronism, hypernatremia or pulmonary edema
- ❑ Member has **NOT** received medications that prolong QT interval or known prolongation of the QT interval or ventricular arrhythmias, including a history of torsade de pointes

❑ Continuation of therapy following inpatient administration

Length of Authorization: Date of Service

- ❑ Member is currently on Contepo for more than 72 hours inpatient **(progress notes must be submitted)**
- ❑ Provider has submitted lab culture sensitivity results retrieved during inpatient admission which shows resistance to **ALL** preferred antibiotics except for Contepo (sensitive)
- ❑ **ONE** of the following must be met:
  - ❑ Member is continuing treatment upon discharge from an acute care facility
  - ❑ Provider has submitted clinical documentation to explain why preferred antibiotics are not an option due to susceptibility, previous failed trials, or other contraindications (i.e., documented severe drug allergies or intolerance to all first line options)

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Medication being provided by: Please check applicable box below.

- ❑ **Location/site of drug administration:** _____

  NPI or DEA # of administering location: _____

  OR

- ❑ **Specialty Pharmacy**

For urgent reviews: Practitioner should call Sentara Health Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara Health's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

*****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;~~ **9/24/2026**
REVISED/UPDATED/REFORMATTED: ~~6/15/2026;~~ **10/15/2026**