SENTARA HEALTH PLANS

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 1-844-668-1550**. 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**.

For Medicare Members: Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Additional indications may be covered at the discretion of the health plan.

Drug Requested: Qutenza® (capsaicin 8% topical system) **(J7336) (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:** _____

- ❑ 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.

Quantity Limit (max daily dose) [NDC Unit]: 4 patches (1120 billable units) every 90 days

NOTE: Qutenza 8% Patch should only be applied by a health care provider in a well-ventilated area.

(Continued on next page)

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.

❑ Postherpetic Neuralgia (PHN)

Initial Authorization: 3 months

- ❑ Requested medication will be used in the management of neuropathic pain associated with postherpetic neuralgia (PHN)
- ❑ Provider has documented the member's baseline Numerical Pain Rating Scale (NPRS) score: _____
- ❑ Member has postherpetic neuralgia that has persisted for at least 6 months following healing of herpes zoster rash (i.e., crusting of the skin vesicles)
- ❑ Painful areas to be treated are **NOT** located on the face, above the hairline of the scalp, and/or in proximity to mucous membranes
- ❑ Member has tried and had an inadequate response (or contraindication) to **BOTH** the following therapies:
  - ❑ Tricyclic antidepressants (e.g., amitriptyline, nortriptyline, maprotiline, desipramine)
  - ❑ Gabapentinoid (e.g., pregabalin, gabapentin)

❑ Diabetic peripheral Neuropathy (DPN)

Initial Authorization: 3 months

- ❑ Provider has documented the member's baseline Numerical Pain Rating Scale (NPRS) score: _____
- ❑ Member has painful, distal, symmetrical, sensorimotor polyneuropathy due to diabetes that has persisted for at least 1 year prior to screening
- ❑ All other causes of pain in the feet have been ruled out
- ❑ Member has tried and had an inadequate response (or contraindication) to **BOTH** the following therapies:
  - ❑ Antidepressants (e.g., duloxetine, venlafaxine, amitriptyline, nortriptyline, maprotiline, desipramine)
  - ❑ Gabapentinoid (e.g., pregabalin, gabapentin)

Reauthorization: 3 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.

Postherpetic Neuralgia (PHN) or Diabetic peripheral Neuropathy (DPN)

- ❑ Member continues to meet all initial authorization criteria

(Continued on next page)

- ❑ Member has experienced an absence of unacceptable toxicity from the drug (e.g., severe application site pain and burning, hypertension, decrease in sensory function)
- ❑ Provider has documented the member's current Numerical Pain Rating Scale (NPRS) score: _____
- ❑ Member has experienced an improvement in pain based on the Numerical Pain Rating Scale (NPRS) compared to baseline

Medication being provided by (check applicable box(es) below):

❑ **Physician's office** **OR** ❑ **Specialty Pharmacy**

For urgent reviews: Practitioner should call the Health Plan Prior Authorization Department if they believe a standard review would subject the member to adverse health consequences. The Health Plan'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: 3/27/2025**
REVISED/UPDATED/REFORMATTED: 6/11/2025