

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: Oral Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)

<input type="checkbox"/> diclofenac/misoprostol 50-0.2 mg (generic Arthrotec)	<input type="checkbox"/> diclofenac/misoprostol 75-0.2 mg (generic Arthrotec)	<input type="checkbox"/> fenoprofen calcium 400 mg (generic Nalfon)
<input type="checkbox"/> fenoprofen calcium 600 mg (generic Nalfon)	<input type="checkbox"/> mefenamic acid 250 mg	<input type="checkbox"/> meclofenamate sodium 50 mg (generic Meclofen)
<input type="checkbox"/> meclofenamate sodium 100 mg (generic Meclofen)	<input type="checkbox"/> Ketoprofen immediate-release 25 mg	

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: _____

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.

- Member must have tried and failed **at least four (4)** of the following (verified by chart notes or pharmacy paid claims):

(Continued on next page)

<input type="checkbox"/> celecoxib	<input type="checkbox"/> ibuprofen	<input type="checkbox"/> nabumetone
<input type="checkbox"/> diclofenac sodium	<input type="checkbox"/> indomethacin IR/ER	<input type="checkbox"/> naproxen
<input type="checkbox"/> diflunisal	<input type="checkbox"/> ketoprofen IR	<input type="checkbox"/> oxaprozin
<input type="checkbox"/> etodolac	<input type="checkbox"/> ketorolac	<input type="checkbox"/> piroxicam
<input type="checkbox"/> flurbiprofen	<input type="checkbox"/> meloxicam	<input type="checkbox"/> sulindac

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 pharmacy paid claims or submitted chart notes.****