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.**

Oral Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)

Drug Requested: Select one drug below

❑ **diclofenac/misoprostol 50-0.2 mg** (generic Arthrotec)	❑ **diclofenac/misoprostol 75-0.2 mg** (generic Arthrotec)	❑ **mefenamic acid 250 mg**
❑ **Ketoprofen immediate-release 50 mg**	❑ **Ketoprofen immediate-release 75 mg**	❑ **tolmetin sodium 200 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:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

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)

❑ celecoxib	❑ ibuprofen	❑ naproxen
❑ diclofenac sodium	❑ indomethacin IR/ER	❑ oxaprozin
❑ diflunisal	❑ ketorolac	❑ piroxicam
❑ etodolac	❑ meloxicam	❑ sulindac
❑ flurbiprofen	❑ nabumetone	

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.****