SENTARA COMMUNITY PLAN
(MEDICAID)

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 the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Platelet Inhibitors

Drug Requested: (check box below that applies)

PREFERRED		
❑ **clopidogrel**	❑ **dipyridamole**	❑ **prasugrel** (generic Effient®)
❑ **ticagrelor**		
Non-Preferred		
❑ **ASA/dipyridamole**	❑ **ASA/Omeprazole** (generic Yosprala®)	❑ **Brilinta®**
❑ **Effient®**	❑ **Plavix®**	
❑ **Yosprala® tab**	❑ **Zontivity®** (PA required)**	

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:** _____

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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.

- ❑ Aspirin and dipyridamole are covered as separate drugs without a Prior Authorization.
- ❑ Trial and failure of **two (2) PREFERRED** drugs. **Please list drugs tried and failed**.

_____

_____

MEDICAL NECESSITY: Provide clinical reason below why aspirin and/or dipyridamole cannot be used separately.

_____

_____

_____

_____

_____

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.*

***REVISED/UPDATED/REFORMATTED:** ~~7/6/2017; 8/31/2017; 8/29/2018; 3/13/2019; 4/18/2019, 11/9/2023,~~**7/8/2026**