

# 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.**

### Phosphodiesterase 5 Inhibitors (PDE-5) Medications

**Drug Requested:** (Check box below that applies)

PREFERRED		
<input type="checkbox"/> Alyq™ (tadalafil) tab	<input type="checkbox"/> sildenafil tab/suspension	<input type="checkbox"/> tadalafil tab
NON-PREFERRED		
<input type="checkbox"/> Revatio® (sildenafil) tab/susp/inj	<input type="checkbox"/> Adcirca® (tadalafil) tab	
<input type="checkbox"/> Liqrev® suspension	<input type="checkbox"/> Opsynvi® tab	
<input type="checkbox"/> Tadliq® suspension	<input type="checkbox"/> Winrevair™ inj	

**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: \_\_\_\_\_

**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.

(Continued on next page)

**PA PDE-5 Inhibitors (Medicaid)**  
(Continued from previous page)

- Prescriber is:**     Pulmonologist                    **OR**                     Cardiologist
- Diagnosis of pulmonary hypertension in members > 18 years of age is required ( $\geq 1$  years oral Revatio<sup>®</sup> only);
- Member tried and failed **two** preferred drugs (if non preferred medication)
- Must have a rationale for not taking the sildenafil tablet to receive a prior authorization for injectable Revatio<sup>®</sup>

---

---

---

**Medication being provided by Specialty Pharmacy - PropriumRx**

***\*\*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.\****