

# 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.

**Drug Requested:** Enstilar® (calcipotriene and betamethasone dipropionate) **Foam (Non-Preferred)**

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

**Length of Authorization: 4 weeks**

**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 has diagnosis of plaque psoriasis
- ☐ Member is  $\geq 12$  years of age
- ☐ Member has had a trial on calcipotriene cream, ointment, or solution

***\*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.\****