

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

### Topical Antifungals

**Drug Requested:** select one drug below

<input type="checkbox"/> <b>luliconazole 1% cream</b> (generic Luzu®)	<input type="checkbox"/> <b>naftifine 2% cream</b> (generic Naftin®)	<input type="checkbox"/> <b>oxiconazole 1% cream</b> (generic Oxistat®)
<input type="checkbox"/> <b>sulconazole 1% solution</b> (generic Exelderm®)	<input type="checkbox"/> <b>tavaborole 5% topical solution</b> (generic Kerydin®)	

**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.

Medication **MUST** be prescribed for treatment of an FDA approved indication (**provide diagnosis below**): \_\_\_\_\_

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□ For luliconazole, naftifine, oxiconazole & sulconazole requests, member must have tried and failed **30 days of therapy** with **TWO** of the following medications (**verified by chart notes or pharmacy paid claims**):

<input type="checkbox"/> ciclopirox 0.77% cream/gel/suspension	<input type="checkbox"/> clotrimazole 0.05%/betamethasone 1% cream	<input type="checkbox"/> econazole 1% cream
<input type="checkbox"/> ketoconazole 2% cream	<input type="checkbox"/> nystatin 100,000 units cream/ointment/powder	<input type="checkbox"/> nystatin 100,000 units/triamcinolone 0.1% cream/ointment

□ For tavaborole requests, member must have tried and failed **12 weeks of therapy** with **BOTH** of the following medications (**verified by chart notes or pharmacy paid claims**):

- oral terbinafine (generic Lamisil®)
- ciclopirox (generic Penlac®)

*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.\****