# 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: Reditrex™** (methotrexate subcutaneous) **(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:** ____________

**DEA OR NPI #:** ______________________________

**DRUG INFORMATION:** Authorization may be delayed if incomplete.

**Drug Form/Strength:** ______________________________

**Dosing Schedule**: ______________________ **Length of Therapy**: ____________

**Diagnosis:** ______________________ **ICD Code, if applicable:** ____________

**Weight:** ______________________ **Date:** ____________

**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.

| ❑ **Diagnosis: Severe Active Rheumatoid Arthritis (RA)** |
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| **Length of Authorization: 12 months** |
| **Starting Doses: 7.5mg once weekly** |

- ❑ Prescribed by or in consultation with a Rheumatologist
- ❑ Failure of generic methotrexate injection, unless contraindicated or clinically significant adverse effects experienced

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| ❑ **Diagnosis: Polyarticular Idiopathic Arthritis (pJIA)** |
|---|
| **Length of Authorization: 12 months** |
| **Starting Doses: 10mg/m$^2$ once weekly** |

- ❑ Member must be 2 years of age and older
- ❑ Failure of generic methotrexate injection, unless contraindicated or clinically significant adverse effects experienced

| ❑ **Diagnosis: Psoriasis** |
|---|
| **Length of Authorization: 12 months** |
| **Starting Doses: 10 to 25 mg once weekly; adjust dose gradually to achieve and optimal response** |

- ❑ For symptomatic control of severe recalcitrant, disabling psoriasis
- ❑ Failure of generic methotrexate injection, unless contraindicated or clinically significant adverse effects experienced

***__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.**