

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 may be delayed.**

Drug Requested: Ophthalmic Antihistamine/Ophthalmic Allergy (select one below)

<input type="checkbox"/> Alocril[®] (nedocromil sodium ophthalmic solution 2%)	<input type="checkbox"/> Alomide[®] (Iodoxamide tromethamine ophthalmic solution 0.1%)	<input type="checkbox"/> bepotastine besilate ophthalmic solution 1.5% (Bepreve [®])
<input type="checkbox"/> Lastacaft[®] (alcaftadine ophthalmic solution 0.25%)	<input type="checkbox"/> Zerviate[™] (cetirizine)	

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: _____

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.

If requesting Alocril, bepotastine, Lastacaft or Zerviate:

- Patient must have documentation of trial and failure of **THREE (3)** of the following (**check each that has been tried; trials will be verified through paid pharmacy claims or chart notes**):

(Continued on next page)

- ketotifen 0.025% ophthalmic solution
- azelastine 0.05% ophthalmic solution
- cromolyn sodium 4% ophthalmic solution
- epinastine 0.05% ophthalmic solution
- olopatadine 0.1% ophthalmic solution
- olopatadine 0.2% ophthalmic solution

If requesting Alomide:

- Patient must have documentation of trial and failure of cromolyn sodium 4% ophthalmic solution (**trials will be verified through paid pharmacy claims or chart notes**)

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.****