# 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)

| | | |
|---|---|---|
| ❑ **Alocril®** (nedocromil sodium ophthalmic solution 2%) | ❑ **Alomide®** (lodoxamide tromethamine ophthalmic solution 0.1%) | ❑ **bepotastine besilate ophthalmic solution 1.5%** (Bepreve®) |
| ❑ **Lastacaft®** (alcaftadine ophthalmic solution 0.25%) | ❑ **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.****