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: Journavx™ (suzetrigine) **(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:** _____

Quantity Limit: 14 days can only be approved every 30 days

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.

Length of Authorization: 14 days

1. Is the member 18 years of age or older?
   - ❑ Yes ❑ No
2. Does the prescriber attest that the member had moderate to severe acute pain?
   - ❑ Yes ❑ No

(Continued on next page)

3. Has the member tried and failed two of the following preferred non-opioid therapies in the past 30 days? (select all that apply)
   - ❑ Diclofenac sodium gel
   - ❑ Acetaminophen
   - ❑ NSAIDs (oral)
   - ❑ Lidocaine patch
   - ❑ Other: _____
4. If the member is of childbearing potential and between 18 and 45 years old, has the prescriber advised members using hormonal contraceptives containing progestins other than levonorgestrel and norethindrone to use an additional nonhormonal contraceptive or to use alternative contraceptives during Journavx™ treatment and for 28 days after discontinuation of Journavx™?
   - ❑ Yes ❑ No ❑ N/A
5. Does the prescriber attest that the member is not pregnant, planning to become pregnant or breastfeeding?
   - ❑ Yes ❑ No ❑ N/A

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.