

# 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.**

**Drug Requested:** Vabomere<sup>®</sup> (meropenem and vaborbactam)

**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.

**Length of Authorization: Date of Service (14 days)**

**New Start**

- Member is 18 years of age or older
- Member has a diagnosis of complicated urinary tract infection (cUTI) or pyelonephritis
- Provider has submitted lab cultures from current hospital admission or office visit collected within the last 7 days
- Lab cultures must show that bacteria is sensitive to Vabomere

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- ❑ Member must meet **ONE** of the following:
  - ❑ Provider must submit chart notes documenting trial and failure of **ALL** the following oral antibiotics: nitrofurantoin, cefdinir, cephalexin, amoxicillin, amoxicillin-clavulanate, ciprofloxacin, levofloxacin, trimethoprim-sulfamethoxazole, and fosfomycin
  - ❑ Cultures (retrieved from most recent office visit or current inpatient admission collected within the last 7 days) shows resistance to **ALL** the following oral antibiotics: nitrofurantoin, cefdinir, cephalexin, amoxicillin, amoxicillin-clavulanate, ciprofloxacin, levofloxacin, trimethoprim-sulfamethoxazole, and fosfomycin
- ❑ Member must meet **ONE** of the following:
  - ❑ Provider must submit chart notes documenting trial and failure of **ALL** the following IV antibiotics: ciprofloxacin, levofloxacin, ceftriaxone, ceftazidime, cefepime, piperacillin-tazobactam, trimethoprim-sulfamethoxazole, gentamicin, tobramycin, amikacin, ertapenem, imipenem-cilastatin, and meropenem
  - ❑ Cultures (retrieved from most recent office visit or current inpatient admission collected within the last 7 days) shows resistance to **ALL** the following IV antibiotics: ciprofloxacin, levofloxacin, ceftriaxone, ceftazidime, cefepime, piperacillin-tazobactam, trimethoprim-sulfamethoxazole, gentamicin, tobramycin, amikacin, ertapenem, imipenem-cilastatin, and meropenem

**Length of Authorization: Date of Service**

**❑ Continuation of therapy following inpatient administration**

- ❑ Member is currently on Vabomere for more than 72 hours inpatient (**progress notes must be submitted**)
- ❑ Provider has submitted lab culture sensitivity results retrieved during admission which shows resistance to **ALL** preferred antibiotics except for Vabomere (sensitive)

**Medication being provided by Specialty Pharmacy – Proprium Rx**

*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.\****