SENTARA HEALTH PLANS

MEDICAL 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 1-844-668-1550**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed**.

For Medicare Members: Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Additional indications may be covered at the discretion of the health plan.

Drug Requested: Primaxin® IV (cilastatin sodium/imipenem) **J0743 (Medical)**

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 Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

❑ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

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**

(Continued on next page)

- ❑ Member has **ONE** of the following diagnoses:
  - ❑ Lower respiratory tract infections
  - ❑ Urinary tract infections
  - ❑ Intra-abdominal infections
  - ❑ Gynecologic infections
  - ❑ Bone and joint infections
  - ❑ Skin and skin structure infections
- ❑ Provider has submitted lab cultures from current hospital admission or office visit collected within the last 7 days
- ❑ Provider must submit chart notes documenting trial and failure of at least **TWO** of the following oral or IV preferred antibiotics within the last 14 days specific to the applicable indication for use:
  - ❑ Lower respiratory tract infections – ceftriaxone, azithromycin, cefepime, doxycycline, and levofloxacin
  - ❑ Urinary tract infections – nitrofurantoin, cefdinir, cephalexin, amoxicillin, amoxicillin-clavulanate, ciprofloxacin, levofloxacin, trimethoprim-sulfamethoxazole, and fosfomycin
  - ❑ Intra-abdominal infections – ciprofloxacin, levofloxacin, ceftriaxone, cefazolin, cefepime, piperacillin-tazobactam, trimethoprim-sulfamethoxazole, ertapenem, imipenem-cilastatin, and meropenem
  - ❑ Gynecologic infections – nitrofurantoin, cefdinir, cephalexin, amoxicillin, amoxicillin-clavulanate, ciprofloxacin, levofloxacin, trimethoprim-sulfamethoxazole, and Fosfomycin
  - ❑ Bone and joint infections – vancomycin, nafcillin, oxacillin, cefazolin, ceftriaxone, daptomycin, cipro, levofloxacin, ceftazidime, and ertapenem,
  - ❑ Skin and skin structure infections – cephalexin, dicloxacillin, cefazolin, ceftriaxone, piperacillin-tazobactam, vancomycin, trimethoprim-sulfamethoxazole, doxycycline, clindamycin, and ciprofloxacin
  - ❑ Endocarditis – vancomycin, ceftriaxone, gentamicin, daptomycin, cefepime, zosyn, tobramycin, meropenem

Length of Authorization: Date of Service

❑ Continuation of therapy following inpatient administration

- ❑ Member has **ONE** of the following diagnoses:
  - ❑ Lower respiratory tract infections
  - ❑ Urinary tract infections
  - ❑ Intra-abdominal infections
  - ❑ Gynecologic infections
  - ❑ Bone and joint infections
  - ❑ Skin and skin structure infections
  - ❑ Endocarditis

(Continued on next page)

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

Medication being provided by: Please check applicable box below.

- ❑ **Location/site of drug administration:** _____

  NPI or DEA # of administering location: _____

  OR

- ❑ **Specialty Pharmacy**

For urgent reviews: Practitioner should call Sentara Health Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara Health's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

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.

***Approved by Pharmacy and Therapeutics Committee**: **3/27/2025**
REVISED/UPDATED: 6/11/2025