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: Qbrexza® (glycopyrronium) **cloth**

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:** _____

Recommended Dosage: Apply to each underarm not more frequently than once every 24 hours using a single cloth

Quantity Limits: 30 towelettes per 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. Check box below for the Diagnosis that applies.

Initial Authorization: 12 months

- ❑ Member is ≥ 9 years of age
- ❑ Member has a diagnosis of Primary Axillary Hyperhidrosis **AND** hyperhidrosis is significantly interfering with the ability to perform age-appropriate activities of daily living
- ❑ Provider has excluded secondary causes of hyperhidrosis

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- ❑ Member must meet **ONE** of the following (**verified by chart notes and/or pharmacy paid claims**):
  - ❑ Member must have an adequate trial and failure of **ONE (1) prescription strength aluminum** chloride-containing topical antiperspirant **for at least 4 weeks and experienced inadequate efficacy** (e.g., **Drysol** (aluminum chloride 20% topical solution))
  - ❑ Member has tried and experienced significant intolerance with an aluminum-containing topical antiperspirant

Reauthorization: 12 months. 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.

- ❑ Member is compliant with therapy **(verified by chart notes and/or pharmacy paid claims)**
- ❑ Member has experienced a positive response to therapy (e.g., decreased axillary sweating) **(submit documentation)**

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.****