

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.**

Long-Acting Beta2 Agonist (LABA) and Inhaled Corticosteroid (ICS) Combination Products

Drug Requested: (select one from below)

<input type="checkbox"/> Advair Diskus (fluticasone and salmeterol)	<input type="checkbox"/> AirDuo[®] Digihaler[®] (fluticasone and salmeterol)
<input type="checkbox"/> AirDuo RespiClick[®] (fluticasone and salmeterol)	<input type="checkbox"/> fluticasone furoate-vilanterol (Breo Ellipta ABA)
<input type="checkbox"/> Symbicort[®] (budesonide and formoterol)	

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: _____

Weight: _____ Date: _____

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.

(Continued on next page)

❑ All criteria must be met for approval of Advair Diskus, AirDuo[®] Digihaler[®], or AirDuo RespiClick[®]:

- ❑ Member must have tried and failed **at least 30 days** of therapy with **ALL** the following:
 - ❑ Breo Ellipta
 - ❑ Breyna[™] (AB-rated generic Symbicort) or budesonide-formoterol (ABA Symbicort)
 - ❑ Dulera[®]
 - ❑ Advair HFA
- ❑ If requesting Advair Diskus, Provider must submit clinical chart notes or a completed MedWatch form documenting the member is intolerant or has a contraindication to fluticasone-salmeterol or Wixela Inhub (generic Advair Diskus)

❑ All criteria must be met for approval of Brand Symbicort[®]:

- ❑ Member must have tried and failed **at least 30 days** of therapy with **ALL** the following:
 - ❑ Breo Ellipta
 - ❑ Breyna[™] (AB-rated generic Symbicort) or budesonide-formoterol (ABA Symbicort)
 - ❑ Dulera[®]
 - ❑ Advair HFA
- ❑ Provider must submit clinical chart notes or a completed MedWatch form documenting the member is intolerant or has a contraindication to Breyna[™] (AB-rated generic Symbicort) or budesonide-formoterol (ABA Symbicort)

❑ All criteria must be met for approval of fluticasone furoate-vilanterol:

- ❑ Member must have tried and failed **at least 30 days** of therapy with **ALL** the following:
 - ❑ Breo Ellipta
 - ❑ Breyna[™] (AB-rated generic Symbicort) or budesonide-formoterol (ABA Symbicort)
 - ❑ Dulera[®]
 - ❑ Advair HFA
- ❑ Provider must submit clinical chart notes or a completed MedWatch form documenting the member is intolerant or has a contraindication to brand Breo Ellipta

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.