# 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 information provided is not complete, correct, or legible, authorization may be delayed.**

**Drug Requested (select one below):**

| | |
|---|---|
| ❑ **aliskiren** (generic Tekturna®) | ❑ **Tekturna HCT®** (aliskren & hydrochlorothiazide) |

**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:** _____

**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.

- ❑ Member has tried and failed at least 30 days of therapy with **BOTH** of the following **(verified by chart notes or pharmacy paid claims):**
  - ❑ **ONE** angiotensin-converting enzyme (ACE) drug or ACE combination drug (e.g., benazepril, captopril, enalapril, fosinopril, lisinopril, perindopril, quinapril, ramipril)
  - ❑ **ONE** angiotensin receptor blocker (ARB) drug or ARB combination drug (e.g., candesartan, losartan, irbesartan, olmesartan, telmisartan)

***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.****

***Approved by Pharmacy and Therapeutics Committee on:** 9/25/2025
**REVISED/UPDATED/REFORMATTED: 10/22/2025**