SENTARA COMMUNITY PLAN
(MEDICAID)

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: select one drug below

❑ **Blujepa®** (gepotidacin)	❑ **Orlynvah ™** (sulopenem etzadroxil and probenecid)

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:

- **Blujepa®:**
  - **uUTI:**1500 mg (two 750 mg tablets) taken orally, twice daily (approximately 12 hours apart) for 5 days
  - **Gonorrhea:** 3000mg (four 750mg tablets) taken orally, followed by a second dose of 3,000mg (four 750mg tablets) approximately 12 hours later
- **Orlynvah™:**
  - **uUTI:** 500-500mg (one tablet) twice daily for 5 days

Quantity Limit: Blujepa: 20 tablets per 30 days; **Orlynvah:** 10 tablets per 30 days

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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**

DIAGNOSIS AND MEDICAL INFORMATION

For Uncomplicated Urinary Tract Infections (uTI)

- BLUJEPA® or ORLYNVAH™ – To obtain a five (5)-day approval for these medications, please complete the following questions. **No renewal**.

For Uncomplicated Urogenital Gonorrhea

- BLUJEPA® – To obtain a one (1)-day approval for this medication, please complete the following questions. **No renewal.**

Specific Criteria for Blujepa

For Uncomplicated Urinary Tract Infections (uTI)

1. Does the member have a diagnosis of uncomplicated urinary tract infections (uTI) and assigned female at birth and is:
   - ❑ ≥ 18 years of age; **OR**
   - ❑ ≥ 12 years of age; **AND**
   - ❑ With a body weight of ≥ 40 kilograms (kg)?
2. Is the member's uTI caused by ≥ 1 of the following susceptible microorganisms: *Escherichia coli, Klebsiella pneumoniae, Citrobacter freundii complex, Staphylococcus saprophyticus or Enterococcus faecalis?*
   - ❑ Yes ❑ No
3. Has the member tried and had an inadequate response or contraindication or intolerance to first-line therapy or alternatives (e.g., nitrofurantoin, trimethoprim/sulfamethoxazole, fosfomycin, amoxicillin/clavulanic acid, ciprofloxacin, levofloxacin)?
   - ❑ Yes ❑ No

For Uncomplicated Urogenital Gonorrhea

4. Does the member have a diagnosis of uncomplicated urogenital gonorrhea and:
   - ❑ ≥ 18 years of age; **OR**
   - ❑ ≥ 12 years of age; **AND**
   - ❑ With a body weight of ≥ 45 kilograms (kg); **AND**
   - ❑ Have limited or no alternative treatment options?

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Blujepa Criteria for All Diagnoses

5. Does the member have severe renal impairment or kidney failure (estimated glomerular filtration rate [eGFR] < 30 mL/min), including receipt of dialysis? Note: This is due to the risk of increased drug levels and QTc prolongation.

   ❑ Yes ❑ No

6. Does the member have severe hepatic impairment (Child-Pugh Class C)? Note: This is due to the risk of increased drug levels and QTc prolongation

   ❑Yes ❑ No

Specific Criteria for Orlynvah

7. Is the member assigned female at birth?

   ❑ Yes ❑ No

8. Does the member have a diagnosis of uncomplicated urinary tract infection (uUTI)?

   ❑ Yes ❑ No

9. Has the member tried and had an inadequate response or contraindication or intolerance to first-line therapy or alternatives (e.g., nitrofurantoin, trimethoprim/sulfamethoxazole, fosfomycin, amoxicillin/clavulanic acid, ciprofloxacin, levofloxacin)?

   ❑ Yes ❑ No

10. Is the member ≥ 18 years of age?

    ❑ Yes ❑ No

11. Is the member's uUTI caused by ≥ 1 of the following susceptible microorganisms: Escherichia coli, Klebsiella pneumoniae, or Proteus mirabilis?

    ❑ Yes ❑ No

12. Does the member have history of uric acid kidney stones?

    ❑ Yes ❑ No

13. Does the prescriber attest that the member is not on concomitant ketorolac tromethamine therapy and will not receive ketorolac tromethamine while on Orlynvah?

    ❑ Yes ❑ No

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**: **11/20/2025**
REVISED/UPDATED/REFORMATTED: ~~12/11/2025~~**, 3/26/2026**