

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.**

The Sentara Health Plans Oncology Program is administered by OncoHealth

- ❖ **For any oncology indications**, the most efficient way to submit a prior authorization request is through the OncoHealth OneUM Provider Portal at <https://oneum.oncohealth.us>. Fax to **1-800-264-6128**.
OncoHealth can also be contacted at Phone: 1-888-916-2616

Drug Requested: Xatmep™ (methotrexate) oral solution (Non-Preferred)

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:

Indication:	Dosage:
Treatment of pediatric patients with acute lymphoblastic leukemia (ALL) as a component of a combination chemotherapy maintenance regimen	• ALL: 20 mg/m ² one time weekly (2.2)
Management of pediatric patients with active polyarticular juvenile idiopathic arthritis (pJIA) who are intolerant of or had an inadequate response to first-line therapy	• Starting dose of 10 mg/m ² one time weekly

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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.

- ☐ Patient has tried and failed **one** of the following:
 - ☐ Methotrexate solution for injection
 - ☐ Methotrexate tablets

Medication being provided by a Specialty Pharmacy – Proprium Rx

****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.