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/m2 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/m2 one time weekly

(Continued on next page)

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 is ≤12 years of age
- ❑ Medication is being used the following indication: Management of pediatric patients with active polyarticular juvenile idiopathic arthritis (pJIA) who are intolerant of or had an inadequate response to first-line therapy

AND

- ❑ Dosing will not allow the use of preferred methotrexate tablets

OR

- ❑ Patient is unable to swallow 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.

REVISED/UPDATED/REFORMATTED: ~~7/19/2021; 11/10/2023;~~ **2/28/2025**