

# 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 by Phone: 1-888-916-2616.

**Drug Requested:** (Select one from below)

metyrosine (Demser®)

phenoxybenzamine (Dibenzylamine®)

**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: \_\_\_\_\_

**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)

- ❑ Member must have a diagnosis of pheochromocytoma

**AND**

- ❑ Provider must submit documentation to confirm resection of the pheochromocytoma is planned or resection of the tumor is contraindicated or has been unsuccessful

**AND**

- ❑ Member must have trial and failure of a selective alpha-blocker e.g., doxazosin, prazosin, terazosin **(verified by chart notes and/or pharmacy paid claims)**

**AND**

- ❑ If requesting generic metyrosine (Demser<sup>®</sup>), trial and failure of generic phenoxybenzamine is required **(verified by chart notes and/or pharmacy paid claims)**

**AND**

- ❑ If requesting brand Demser<sup>®</sup>, trial and failure of generic metyrosine **AND** phenoxybenzamine is required **(verified by chart notes and/or pharmacy paid claims)**

**AND**

- ❑ If requesting brand Dibenzyl<sup>®</sup>, trial and failure of generic phenoxybenzamine is required **(verified by chart notes and/or pharmacy paid claims)**

*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.\**