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 the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Non-Preferred Inhaled Corticosteroids (ICS)

Drug Requested: (select one from below)

❑ **Alvesco®** (ciclesonide)	❑ **ArmonAir® Digihaler®** (fluticasone propionate)
❑ **Asmanex® HFA/Twisthaler** (mometasone furoate)	❑ **Flovent Diskus/HFA** (fluticasone propionate)
❑ **fluticasone propionate Diskus/HFA** (Flovent Diskus/HFA ABA)	

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:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

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)

- ❑ **For all non-preferred inhaled corticosteroids (Alvesco, ArmonAir Digihaler, Asmanex HFA/Twisthaler, Flovent Diskus/HFA, fluticasone propionate Diskus/HFA) the following criteria must be met:**
  - ❑ Member must have tried and failed at least **30 days** of therapy with **ONE (1)** of the following:
    - ❑ Arnuity Ellipta®
    - ❑ Pulmicort Flexhaler®
    - ❑ Qvar/Redihaler®

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:** ~~2/21/2019;~~ **9/21/2023**
REVISED/UPDATED: ~~6/3/2020; 6/21/2022; 9/15/2022;~~ **12/01/23**