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: Kineret™ (anakinra) **(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 dose and quantity limit: One syringe per day (maximum quantity 30/30 days)

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.

- ❑ **Diagnosis: Moderate to severe Active Rheumatoid Arthritis**
  - ❑ Member is 18 years of age or older

(Continued on next page)

- ❑ Member has a diagnosis of **moderate to severely active rheumatoid arthritis**
- ❑ Trial and failure of methotrexate **OR**
- ❑ Member has a contraindication to methotrexate (e.g., alcohol abuse, cirrhosis, chronic liver disease, or other contraindication)
- ❑ Trial and failure of at least **ONE (1) other DMARD (check each tried):**

❑ azathioprine	❑ leflunomide	❑ auranofin	❑ sulfasalazine
❑ hydroxychloroquine	❑ minocycline	❑ Oher: _____	

- ❑ Trial and failure of **TWO (2)** of the preferred biologics below:

❑ Humira®	❑ Enbrel®	❑ Infliximab

❑ Diagnosis: Cryopyrin-Associated Periodic Syndromes (CAPS)
Approvable with confirmation of this diagnosis.

- ❑ Cryopyrin -Associated Periodic Syndromes (CAPS), including:
  - ❑ Treatment of Neonatal-Onset Multisystem Inflammatory Disease

❑ Diagnosis: Deficiency of Interleukin-1 Receptor Antagonist (DIRA)
Approvable with confirmation of this diagnosis.

- ❑ Deficiency of Interleukin-1 Receptor Antagonist (DIRA)

Medication being provided by (check applicable box(es) below):

❑ **Physician's office** **OR** ❑ **Specialty Pharmacy – PropriumRx**

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.

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