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 information provided is not complete, correct, or legible, authorization may be delayed.**

Non-Preferred Incretin Mimetic Drugs

Drug Requested: (Check below the drug that applies)

Preferred Drugs* *No prior authorization required for Preferred drugs	
❑ **Byetta®**	❑ **Trulicity™**
❑ **Victoza®**	
Non-Preferred Drugs Require prior authorization and 2 (two) preferred drugs must be tried and failed first	
❑ **Adlyxin™**	❑ **Bydureon™ Bcise SQ**
❑ **Mounjaro®**	❑ **Ozempic®**
❑ **Rybelsus®**	❑ **Soliqua®**
❑ **Tanzeum™**	❑ **Xultophy®**

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:** _____

Weight: _____ **Date:** _____

(Continued on next page)

CLINCIAL 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.

Initial Approval: 12 months

Does the member meet the following criteria?

1. Does the member have a diagnosis of Type 2 Diabetes Mellitus?

   ❑ Yes ❑ No

   If **Yes**, please provide the value of the lab that was performed within the last 12 months and has been used to confirm the member's diagnosis along with the date of the result (**A1c of greater than or equal to 6.5 is required for first starts**):

   ❑ **A1c**. Value _____Date: _____

2. Has the member tried and failed 2 different preferred products?

   ❑ Yes ❑ No

   If **Yes,** please specify the drug, the length of the member's trial, and reason for discontinuation.

   Drug 1: _____

   Drug 2: _____

*****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.****