

# 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.**

**Drug Requested:** (select one below)

<input type="checkbox"/> Zyflo <sup>®</sup> (zileuton)	<input type="checkbox"/> zileuton extended-release
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**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: \_\_\_\_\_

**Maximum Quantity Limit:** 600mg daily; 4 tablets per day

**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.

Member must be 12 years of age or older;

**AND**

Member must have a confirmed diagnosis of asthma;

**AND**

(Continued on next page)

- ❑ Member must have trial and failure of a combination inhaled corticosteroid/long-acting beta-2 agonist product (e.g. Symbicort, Advair) for **at least 3 months** (chart notes documenting therapy failures must be submitted)

**AND**

- ❑ Member must have a **30-day trial and failure** of **BOTH** montelukast **AND** zafirlukast (chart notes documenting therapy failures must be submitted)

**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.\***