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.**

Drug Requested: Rasuvo™ (methotrexate) **(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:** _____

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:** _____

Quantity Limit: 4 autoinjectors per month

CLINICAL CRITERIA AND DIAGNOSES: 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. Check diagnosis below that applies.

❑ **Diagnosis: Active Rheumatoid Arthritis (RA)**

Length of Authorization: 6 months, then renew for 1 year, if compliant and appropriate monitoring occurs.

❑ Has had therapeutic failure to **two (2) Preferred DMARD** agents;

AND

❑ Must have allergy or contraindication to benzoyl alcohol or other preservative contained in generic injectable methotrexate

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❑ **Diagnosis: Polyarticular Juvenile Idiopathic Arthritis (pJIA)**

- ❑ Has had therapeutic failure to **two (2)** **Preferred** **NSAIDS** agents

AND

- ❑ Must have allergy or contraindication to benzoyl alcohol or other preservative contained in generic injectable methotrexate

❑ **Diagnosis: Psoriasis**

Length of Authorization: 6 months

- ❑ A therapeutic trial and failure on topical therapies such as topical emollients and/or topical corticosteroids, topical retinoids, topical vitamin D analogs, and topical tacrolimus, **AND** pimecrolimus

AND

- ❑ Must have allergy or contraindication to benzoyl alcohol or other preservative contained in generic injectable methotrexate.

RENEWAL AUTHORIZATION: For renewal, member must be followed by a physician for monitoring of renal and hepatic function and complete blood counts with differential and platelet count.

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.

REVISED/UPDATED/REFORMATTED: ~~12/30/2018; 9/7/2019,~~**11/9/2023**