

# 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: \_\_\_\_\_

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: \_\_\_\_\_

**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.

☐ Patient has tried and failed **one** of the following:

☐ Methotrexate solution for injection

☐ Methotrexate tablets

***\*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.\****