

# 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.**

### ESTROGEN AGENTS

**Drug Requested:** (Check below the drug that applies)

|                                                                                                                                                                                              |                                                                      |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|
| <b>ORAL PREFERRED MEDICATIONS</b><br>(Does not require Prior Authorization if 18 or older)                                                                                                   |                                                                      |
| <input type="checkbox"/> estradiol                                                                                                                                                           | <input type="checkbox"/> Premarin®                                   |
| <b>ORAL NON-PREFERRED</b><br>All Non-Preferred Medications Require Prior Authorization (Member must have tried and failed at least two (2) of the Preferred <b>ORAL</b> drugs)               |                                                                      |
| <input type="checkbox"/> Duavee®                                                                                                                                                             | <input type="checkbox"/> estrogens, conjugated                       |
| <input type="checkbox"/> Osphena®                                                                                                                                                            |                                                                      |
| <b>TRANSDERMAL PREFERRED MEDICATIONS</b><br>(Does not require Prior Authorization if 18 or older)                                                                                            |                                                                      |
| <input type="checkbox"/> Climara®                                                                                                                                                            | <input type="checkbox"/> Divigel®                                    |
| <input type="checkbox"/> Elestrin®                                                                                                                                                           | <input type="checkbox"/> Evamist®                                    |
| <input type="checkbox"/> Vivelle-Dot®                                                                                                                                                        |                                                                      |
| <b>TRANSDERMAL NON-PREFERRED</b><br>All Non-Preferred Medications Require Prior Authorization (Member must have tried and failed at least two (2) of the <b>TRANSDERMAL</b> Preferred drugs) |                                                                      |
| <input type="checkbox"/> Dotti™                                                                                                                                                              | <input type="checkbox"/> estradiol once weekly patch, pump (Climara) |
| <input type="checkbox"/> estradiol packet (Divigel)                                                                                                                                          | <input type="checkbox"/> estradiol twice weekly (Minivelle)          |
| <input type="checkbox"/> estradiol twice weekly (Vivelle-Dot)                                                                                                                                | <input type="checkbox"/> Lyllana®                                    |
| <input type="checkbox"/> Menostar®                                                                                                                                                           | <input type="checkbox"/> Minivelle twice weekly                      |

(Continued on next page)

**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:** 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.

- ☐ For Non-Preferred drugs, member has tried and failed at **least two (2) Preferred** drugs **from the corresponding class** (oral, transdermal) ☐ Yes ☐ No

Provide clinical evidence that the **Preferred** drug(s) will not provide adequate benefit and list pharmaceutical drugs attempted and outcome.

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***\*\*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.\****