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

Drug Requested: (select one of the following)

❑ **ibuprofen/famotidine** (Duexis®)	❑ **naproxen/esomeprazole magnesium** (Vimovo®)

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 Limits:

- ibuprofen/famotidine (generic Duexis®) – 90 tablets per 30 days
- naproxen/esomeprazole magnesium (generic Vimovo®) – 60 tablets per 30 days

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 has tried and failed at least **FOUR** generic Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) **(select all that apply; verified by chart notes and/or pharmacy paid claims)**

❑ celecoxib	❑ ibuprofen	❑ nabumetone
❑ diclofenac sodium	❑ indomethacin IR/ER	❑ naproxen
❑ diflunisal	❑ ketoprofen IR	❑ oxaprozin
❑ etodolac	❑ ketorolac	❑ piroxicam
❑ flurbiprofen	❑ meloxicam	❑ sulindac

(Continued on next page;

- ❑ Member has tried and failed at least **ONE** of the following **(select all that apply; verified by chart notes and/or pharmacy paid claims)**:

❑ esomeprazole	❑ famotidine	❑ lansoprazole
❑ omeprazole	❑ pantoprazole	❑ rabeprazole

- ❑ Member has tried and had an adequate response (defined as pain relief and appropriate gastro protection) with a trial of naproxen or ibuprofen and a proton pump inhibitor (such as esomeprazole) or histamine receptor antagonist (such as famotidine) used at the same time

- ❑ Provider has submitted chart notes to document the clinical rationale for why requested combination agent is medically necessary and not only for convenience

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.****