SENTARA COMMUNITY PLAN
(MEDICAID)

MEDICAL 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 1-844-305-2331**. 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 can be delayed**.

Drug Requested: (select **ONE** of drugs below) **(Medical)**

❑ **Istodax®** (romidepsin, lyophilized) **(J9319)**	❑ **romidepsin** (non-lyophilized) **(J9318)**

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:** _____

❑ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

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.

Initial Authorization: 12 months

- ❑ Member is 18 years of age or older
- ❑ Prescribed by or in consultation with an oncology specialist

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- ❑ Member's diagnosis and treatment status meet **ONE** of the following:
  - ❑ Member has a diagnosis of cutaneous T-cell lymphoma **AND** has tried and had an inadequate response, intolerance or contraindication to at least **ONE** prior therapy (e.g., retinoids, corticosteroids)
  - ❑ Member has a diagnosis of peripheral T-cell lymphoma **AND** has tried and had an inadequate response, intolerance or contraindication to at least **ONE** prior therapy (e.g., conventional chemotherapy, stem cell transplant)
  - ❑ Used as single agent therapy for relapsed or refractory disease for Breast Implant-Associated Anaplastic Large Cell Lymphoma (ALCL)

Reauthorization: 12 months. 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 is currently receiving the requested agent and ongoing treatment is consistent with FDA-labeling or compendia support **(please submit medical chart notes and documentation of therapy history)**
- ❑ Member requires continuation of therapy and is **NOT** experiencing disease progression
- ❑ Member is **NOT** experiencing an FDA-labeled limitation of use or toxicity

Medication being provided by (check applicable box(es) below):

- ❑ **Location/site of drug administration:** _____

  NPI or DEA # of administering location: _____

  OR

- ❑ **Specialty Pharmacy – Proprium Rx**

For urgent reviews: Practitioner should call Sentara Health Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara Health's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

*****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.****