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 the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Topical Rosacea Drugs

Drug Requested: (check applicable box below)

❑ **brimonidine** (Mirvaso®)	❑ **Rhofade®** (oxymetazoline)
❑ **ivermectin** (Soolantra®)	

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 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 brimonidine (Mirvaso®) and Rhofade® requests, ALL the following criteria must be met:**

- ❑ Member is 18 years of age or older
- ❑ Member's quality of life has been impacted

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- ❑ Member has **ONE** of the following diagnosis:
  - ❑ Persistent (non-transient) facial erythema (subtype erythematotelangiectatic rosacea)
  - ❑ Papulopustular lesions with persistent (non-transient) facial erythema (subtype erythematotelangiectatic rosacea)
- ❑ Member has tried and failed **at least 30 days** of therapy with **two (2)** of the following within the last 6 months **(submit chart notes documenting treatment failure)**:

❑ azelaic acid gel 15%	❑ Oral doxycycline hyclate	❑ Oral minocycline	❑ Oral tetracycline
❑ metronidazole cream 0.75%, ❑ metronidazole 0.75% gel ❑ metronidazole 1% gel	❑ sodium sulfacetamide sulfur 10%/5%	❑ Topical retinoids (e.g., adapalene, tretinoin) **(*requires prior authorization)**	

❑ **For ivermectin (Soolantra®) requests, ALL the following criteria must be met:**

- ❑ Member must have papulopustular rosacea and inflammatory lesions
- ❑ Member has tried and failed **at least 30 days** of therapy with **two (2)** of the following within the last 6 months **(submit chart notes documenting treatment failure)**:

❑ azelaic acid gel 15%	❑ Oral doxycycline hyclate	❑ Oral minocycline	❑ Oral tetracycline
❑ metronidazole cream 0.75%, ❑ metronidazole 0.75% gel ❑ metronidazole 1% gel	❑ sodium sulfacetamide sulfur 10%/5%	❑ Topical retinoids (e.g., adapalene, tretinoin) **(*requires prior authorization)**	

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.****

***Approved by Pharmacy and Therapeutics Committee**: ~~4/21/2016;~~ ~~7/21/2022;~~ **9/25/2025**
REVISED/UPDATED: ~~5/9/2016;~~ ~~12/20/2016;~~ ~~8/19/2017;~~ ~~12/7/2020;~~ ~~6/7/2022;~~~~08/22/2022;~~ ~~10/27/2023,~~ **12/30/2025**