

# 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:** Furoscix<sup>®</sup> (furosemide)

**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: \_\_\_\_\_

Weight: \_\_\_\_\_ Date: \_\_\_\_\_

**Quantity Limit:** 2 on-body infusors per fluid overload episode (max of 2 per fill)

**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: 6 months**

- Member is 18 years of age or older
- Member has a diagnosis of New York Heart Association (NYHA) Class II or III chronic heart failure
- Member is experiencing congestion due to fluid overload
- Member does **NOT** have anuria or hepatic cirrhosis or ascites
- Member does **NOT** have a hypersensitivity to furosemide or medical adhesives
- Member does **NOT** have acute pulmonary edema

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- ❑ Prescriber attests, Furoscix will **NOT** be prescribed for an emergency situation
- ❑ Prescriber attests the member requires a non-oral route of administration of a loop diuretic for congestion due to fluid overload in chronic heart failure
- ❑ Prescriber attests the member will be monitored outpatient for fluid, electrolyte, and metabolic abnormalities

**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 must have disease improvement and/or stabilization **OR** improvement in the slope of decline (e.g., improvement in signs/symptoms of fluid overload – edema, dyspnea, rapid weight gain)
- ❑ Member has **NOT** experienced any treatment-restricting adverse effects (e.g., fluid, electrolyte, or metabolic abnormalities, worsening renal function, ototoxicity, acute urinary retention)

*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.\****