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: Epioxa™ (riboflavin 5'-phosphate ophthalmic solution) **MEDICAL (J2789)**

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:** _____

❑ 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: 6 months – up to one kit per eye

❑ Member is 13 years of age or older

❑ Prescribed by or in consultation with an ophthalmologist

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- ❑ Member has a diagnosis of progressive keratoconus confirmed by **ALL** the following **(submit documentation)**:
  - ❑ Maximum corneal curvature as measured by Kmax of ≥ 47.00 D
  - ❑ Presence of central or inferior steepening on the Pentacam topography map
  - ❑ Presence of at least **ONE** of the following findings associated with keratoconus **(select all that apply)**:
    - ❑ Fleischer ring
    - ❑ Vogt striae
    - ❑ Corneal thinning
    - ❑ Corneal scarring
    - ❑ Scissoring of the retinoscopic reflex
- ❑ Dose does **NOT** exceed one kit per eye

Reauthorization: 6 months – up to one kit per eye. 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.

Provider please note: Approval of the drug does NOT translate to an approval of the corneal cross-linking procedure

- ❑ At least 6 months have passed since member's last collagen cross linking procedure**(submit documentation)**
- ❑ Member is responding positively to therapy as evidenced by a reduction in diopters in the treated eye(s) **(submit documentation)**
- ❑ If request is for a dose increase, new dose does **NOT** exceed one kit per eye

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

❑ **Physician's office** **OR** ❑ **Specialty Pharmacy**

For urgent reviews: Practitioner should call Sentara Health Plans Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara Health Plan'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.*

Approved by Pharmacy and Therapeutics Committee: 5/28/2026
REVISED/UPDATED/REFORMATTED: 6/15/2026