SENTARA COMMUNITY PLAN
(MEDICAID)

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 will be delayed.**

Oral Cephalosporins

DRUG REQUESTED: Check box below that applies or authorization will be delayed.

PREFERRED			
❑ cefaclor cap	❑ cefprozil tab/susp	❑ cefuroxime tab	❑ cefdinir cap/susp
Non-Preferred			
❑ cefaclor ER	❑ cefaclor susp	❑ Ceftin® tab/susp	❑ Cedax® cap/susp
❑ ceftibuten	❑ cefditoren pivoxil	❑ cefixime suspension	❑ cefpodoxime proxetil cap/susp
❑ Spectracef®	❑ Suprax® chewable tab/cap/susp		

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:** _____

Length of Authorization: Date of Service Only; no refills

(Continued on next page)

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.

- ❑ Is infection caused by an organism resistant to preferred drugs? ❑ Yes ❑ No

OR

- ❑ Is therapeutic failure to no less than a **three-day trial** of **ONE (1) Preferred cephalosporin**?

❑ Yes ❑ No

OR

- ❑ Is member completing a course of therapy with a non-preferred drug which was initiated in the hospital?

❑ Yes ❑ No

MEDICAL NECESSITY: Provide clinical evidence that the **Preferred** drug(s) will **not** provide adequate benefit.

_____

_____

_____

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.

REVISED/UPDATED: ~~6/29/2017; 8/28/2017; 8/17/2018;06/12/2019;~~ **11/8/2023**