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

Drug Requested: Mytesi™ (crofelemer) **(formerly Fulyzaq®)**

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:** _____

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.

Authorization Approval Length: Three (3) months

1) Is member 18 years of age or older? ❑ Yes ❑ No
2) Does member have diagnosis of HIV/AIDS? ❑ Yes ❑ No
3) Is member currently on anti-retroviral therapy? ❑ Yes ❑ No
4) What antidiarrheal(s), if any, has member tried? Please list names:

   _____

   _____
5) Has infectious diarrhea been ruled out? ❑ Yes ❑ No
6) Does member have any other GI conditions or medications that can cause diarrhea? ❑ Yes ❑ No

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/REFORMATTED: ~~12/23/2017~~; ~~8/27/2018~~; ~~4/4/2019~~; **11/10/2023**