# 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: Relyvrio™** (Sodium Phenylbutyrate and Taurursodiol)

**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:** _____

## Recommended Dosage:

- Initial: Oral: One packet (sodium phenylbutyrate 3 g/taurursodiol 1 g) once daily for 3 weeks, then increase dose to 1 packet twice daily, if tolerated

## Quantity Limits:

- 2 packets per day

**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**

- ❑ Prescriber is a Neurologist
- ❑ Member is ≥ 18 years of age

**(Continued on next page)**

- ❑ Member has a diagnosis of amyotrophic lateral sclerosis (ALS) **(submit documentation)**
- ❑ Member has tried and failed at least 60 days of therapy with **BOTH** of the following **(verified by chart notes or pharmacy paid claims)**:
  - ❑ riluzole
  - ❑ Radicava
- ❑ Provider has assessed member's baseline disease severity utilizing an objective measure/tool (e.g., ALS Functional Rating Scale-Revised (ALSFRS-R)) **(submit documentation)**
- ❑ Member does **NOT** require permanent assisted ventilation

**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.

- ❑ Functionality retained for most activities of daily living (defined as total score from baseline did **NOT** decrease by more than 10 points on the ALS Functional Rating Scale-Revised (ALSFRS-R)
- ❑ Member has **NOT** experienced any unacceptable toxicity from treatment (e.g., worsening hypertension or heart failure)

**Medication being provided by Specialty Pharmacy - PropriumRx**

*****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.****