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

**Drug Requested: Glaucoma Drugs** (Select one from below)

| | |
|---|---|
| ❑ **Betoptic-S®** (betaxolol hydrochloride) | ❑ **tafluprost** (generic Zioptan) |
| ❑ **brimonidine 0.1%** (generic Alphagan-P) | ❑ **timolol** (generic Betimol®) |
| ❑ **Rhopressa®** (netarsudil) | ❑ **travoprost 0.004%** (generic Travatan Z) |
| ❑ **Rocklatan®** (netarsudil/latanoprost) | ❑ **Vyzulta®** (latanoprostene bunod) |
| ❑ **Simbrinza®** (brinzolamide/brimonidine tartrate) | |

**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 Form/Strength:** _____

**Dosing Schedule**: _____ **Length of Therapy**: _____

**Diagnosis:** _____ **ICD Code, if applicable:** _____

**Weight (if applicable):** _____ **Date weight obtained:** _____

**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.

**(Continued on next page)**

❑ **If requesting travoprost 0.004% (Travatan Z), Vyzulta®, or tafluprost (Zioptan):**

- ❑ Member must have tried and failed at least **30 days** of therapy with latanoprost **AND ONE** of the following:
  - ❑ bimatoprost
  - ❑ Lumigan 0.01%

❑ **If requesting Betoptic-S® or timolol (generic Betimol®):**

- ❑ Member must have tried and failed at least **30 days** of therapy with **TWO** of the following:
  - ❑ levobunolol
  - ❑ betaxolol
  - ❑ timolol
  - ❑ carteolol

❑ **If requesting brimonidine 0.1% (Alphagan-P):**

- ❑ Member must have tried and failed at least **30 days** of therapy with **BOTH** of the following:
  - ❑ brimonidine 0.15% or brimonidine 0.2%
  - ❑ apraclonidine

❑ **If requesting Rhopressa®, Rocklatan® and Simbrinza®:**

- ❑ Member must have tried and failed at least **30 days** of therapy with **ONE** of the following:
  - ❑ latanoprost
  - ❑ bimatoprost
  - ❑ Lumigan 0.01%
- ❑ Member must have tried and failed at least **30 days** of therapy with **ONE** of the following:
  - ❑ levobunolol or betaxolol or timolol or carteolol
  - ❑ brimonidine or apraclonidine
  - ❑ dorzolamide
  - ❑ timolol-dorzolamide

***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.****



***Approved by Pharmacy and Therapeutics Committee:** ~~9/17/2020;~~ **11/16/2023**
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