

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)

<input type="checkbox"/> Betoptic-S® (betaxolol hydrochloride)	<input type="checkbox"/> Simbrinza® (brinzolamide/brimonidine tartrate)
<input type="checkbox"/> brimonidine 0.1% (generic Alphagan-P)	<input type="checkbox"/> tafluprost (generic Zioptan)
<input type="checkbox"/> Omlonti® (omidenepeg isopropyl)	<input type="checkbox"/> timolol (generic Betimol®)
<input type="checkbox"/> Rhopressa® (netarsudil)	<input type="checkbox"/> travoprost 0.004% (generic Travatan Z)
<input type="checkbox"/> Rocklatan® (netarsudil/latanoprost)	<input type="checkbox"/> Vyzulta® (latanoprostene bunod)

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 Omlonti[®], 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.