# 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: Xdemvy™** (lotilaner ophthalmic solution) 0.25%

**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:** ______________

**Quantity Limit**: 10 mL per 365 days

**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.

**Length of Authorization: 6 weeks**

- ❑ Member is 18 years of age or older
- ❑ Prescribed by or in consultation with an eye specialist (e.g., ophthalmologist, optometrist)
- ❑ Member has a diagnosis of blepharitis due to Demodex infestation confirmed by the presence of **ALL** the following in **at least one (1) eye**:
  - ❑ Demodex infestations with >10 lashes with collarettes present on the upper lid (collarette scale grade 2 or worse)

**(Continued on next page)**

- ❑ Mild erythema of the upper eyelid margin
- ❑ Average mite density of > 1.5 mites per lash (upper and lower eyelids combined)

**Reauthorization: Coverage may NOT be renewed. Reauthorization will not be granted as Xdemvy has NOT been studied beyond 6 weeks of therapy or for re-treatment.**

**Medication being provided by Specialty Pharmacy – Proprium Rx**

*****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**: 9/21/2023
**REVISED/UPDATED:** ~~10/17/2023;~~ **01/26/2024**