

SENTARA COMMUNITY PLAN (MEDICAID)

MEDICAL 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 1-844-305-2331. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. If information provided is not complete, correct, or legible, authorization can be delayed.

Drug Requested: Xenleta™ (lefamulin) for IV Infusion (Medical) (J0691/C9054)

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: _____

- Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

INFORMATIONAL NOTE: IV Formulation for treatment in an inpatient setting (chart notes, medication orders/history need to accompany this request). Switching to oral formulation will require prior authorization.

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.

- The patient has a diagnosis for Community Acquired Bacterial Pneumonia (CABP)
- If classified as Severe CABP, sputum and/or blood cultures are attached observing susceptible pathogens

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- ALL of the following have been tried:
 - Beta-lactam antibiotic (ampicillin/sulfabactam, cefotaxime, ceftriaxone) PLUS a macrolide antibiotic (azithromycin, clarithromycin)
 - Monotherapy with a respiratory fluoroquinolone
 - Beta-lactam antibiotic PLUS doxycycline
- Document any intolerabilities/contraindications/resistance to the above therapies (include medical documentation):

Medication being provided by (check box below that applies):

- Location/site of drug administration: _____
NPI or DEA # of administering location: _____

OR

- Specialty Pharmacy – PropriumRx

For urgent reviews: Practitioner should call Sentara Health Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara Health's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

*****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.****