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: Otrexup™ (methotrexate subcutaneous) **(Non-Preferred)**

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:** _____

CLINICAL CRITERIA: Check below all that apply. All criteria and diagnoses 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.

Diagnosis: Active Rheumatoid Arthritis (RA)

Length of Authorization: 6 months, then renew for 1 year, if compliant and appropriate monitoring occurs.

- ❑ Has had therapeutic failure to **two (2) Preferred DMARD** agents; **AND**
- ❑ Must have allergy or contraindication to benzoyl alcohol or other preservative contained in generic injectable methotrexate

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Diagnosis: Polyarticular Juvenile Idiopathic Arthritis (pJIA)

- ❑ Has had therapeutic failure to **two (2) Preferred NSAIDS** agents; **AND**
- ❑ Must have allergy or contraindication to benzoyl alcohol or other preservative contained in generic injectable methotrexate

Dianosis: Psoriasis

Length of Authorization: 6 months

- ❑ A therapeutic trial and failure on topical therapies such as topical emollients and/or topical corticosteroids, topical retinoids, topical vitamin D analogs, and topical tacrolimus, AND pimecrolimus

AND

- ❑ Must have allergy or contraindication to benzoyl alcohol or other preservative contained in generic injectable methotrexate.

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.

REVISED/UPDATED/REFORMATTED: ~~7/2/2017; 8/31/2017; 8/29/2018; 12/9/2018; 1/3/2020;;~~ **11/9/2023**