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: Panretin® Gel (alitretinoin)

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 Name/Form/Strength: _____

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

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

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

Recommended Dosing: Initial: Apply gel twice daily to cutaneous lesions; may gradually increase application frequency to 3 or 4 times daily based on lesion tolerance. Continue as long as deriving clinical benefit; response may be observed within 2 weeks of initiation; however, most patients require a longer period, and further benefit may be attained with a longer application period (>14 weeks) in some patients.

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.

Initial Authorization: 12 months

- ❑ Member is 18 years of age or older
- ❑ Medication is prescribed by or in consultation with a dermatologist, oncologist, or infectious disease specialist
- ❑ Member has been diagnosed with cutaneous lesions in AIDS-related Kaposi's sarcoma (KS)

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- ❑ Member must **NOT** have any of the following exclusions from therapy:
  - Receiving systemic therapy for Kaposi sarcoma
  - Diagnosed with advanced cutaneous, oral visceral, or nodal disease
  - More than 10 new KS lesions in the previous month, symptomatic lymphedema, or symptomatic pulmonary KS

Reauthorization: 12 months. 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.

- ❑ Member continues to derive a positive clinical response treatment
- ❑ Member must **NOT** have any of the following exclusions from therapy:
  - Receiving systemic therapy for Kaposi sarcoma
  - Diagnosed with advanced cutaneous, oral visceral, or nodal disease
  - More than 10 new KS lesions in the previous month, symptomatic lymphedema, or symptomatic pulmonary KS
- ❑ Member has experienced an absence of unacceptable toxicity from the drug (e.g., grade 3 dermal irritation)

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.****