# 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:** (select applicable drug below)

| | |
|---|---|
| ❑ **Soliqua®** (insulin glargine and lixisenatide injection) | ❑ **Xultophy®** (insulin degludec and liraglutide injection) |

**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 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 must have trial and failure of **BOTH** the following medication classes **(verified by chart notes and/or pharmacy paid claims)**:
  - ❑ Member has tried and failed at least **30 days** of therapy with **at least one** preferred **GLP-1 Receptor Agonist** medication (e.g., Ozempic, Trulicity). Please specify previously failed therapy: _____
  - ❑ Member has tried and failed at least **30 days** of therapy with **at least one** preferred **Long-Acting Insulin** medication:

| | | |
|---|---|---|
| ❑ Lantus® | ❑ Toujeo® | ❑ Tresiba |

**(Continued on next page)**

***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.****