

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.

Pancreatic Enzymes

DRUG REQUESTED: Check box below that applies.

PREFERRED Pancrelipase	Non-Preferred Pancrelipase
<input type="checkbox"/> Creon [®]	<input type="checkbox"/> Pertzye [®]
<input type="checkbox"/> Zenpep [®]	<input type="checkbox"/> Viokace [®]

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: _____

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.

Lenth of Authorization: 1 year

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PA Pancreatic Enzymes (Preferred) (Medicaid)

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- Member has a diagnosis of pancreatic insufficiency
- Member has tried and failed **BOTH** of the preferred drugs below:

<input type="checkbox"/> Creon®	<input type="checkbox"/> Zenpep®
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For **All** drugs preferred and non-preferred:

- If member has a diagnosis of Cystic Fibrosis, there is **no** requirement to try and fail a preferred
- If member has a feeding tube, then 2 different pancreatic enzymes can be approved for use together.

*****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.****