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 information provided is not complete, correct, or legible, authorization may be delayed.**

Long-Acting Antimuscarinic (LAMA) and Long-Acting Beta2 Agonist (LABA) Combination Products

Drug Requested: (Select one from below)

❑ **Bevespi Aerosphere®** (glycopyrrolate and formoterol)	❑ **Breztri®** (budesonide, glycopyrrolate and formoterol)
❑ **Duaklir Pressair®** (aclidinium and formoterol)	

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 Form/Strength: _____

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

Diagnosis: _____ **ICD Code:** _____

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.

❑ Diagnosis: Chronic Obstructive Pulmonary Disease (COPD)

- ❑ Member is 18 years of age or older
- ❑ Provider attests member has a diagnosis of COPD

(Continued on next page)

- ❑ Member must have tried and failed **at least 30 days** of **ONE** of the following **(verified by chart notes and/or pharmacy paid claims)**:
  - ❑ Anoro Ellipta®
  - ❑ Trelegy Ellipta®
- ❑ Member must have tried and failed **at least 30 days** of Stiolto Respimat® **(verified by chart notes and/or pharmacy paid claims)**

❑ Diagnosis: Asthma

- ❑ **For members 12 to 17 years of age:**
  - ❑ Provider attests member has a diagnosis of asthma
  - ❑ Provider is requesting Breztri® (budesonide 160 mcg, glycopyrrolate 18 mcg, & formoterol 4.8 mcg)
- ❑ **For members 18 years of age or older:**
  - ❑ Provider attests member has a diagnosis of asthma
  - ❑ Provider is requesting Breztri® (budesonide 160 mcg, glycopyrrolate 18 mcg, & formoterol 4.8 mcg)
  - ❑ Member must have tried and failed **at least 30 days** of Trelegy Ellipta® **(verified by chart notes and/or pharmacy paid claims)**

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.*