

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 may be delayed.**

Drug Requested: Cresemba[®] (isavuconazonium sulfate) capsules (**Pharmacy**)

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: _____

Recommended Dosage in Adult Patients:

<u>Dosage Form</u>	<u>Loading Dose</u>	<u>Maintenance Dose*</u>	<u>Quantity Limit</u>
186 mg capsules	Two 186 mg capsules (372 mg) orally every 8 hours for 6 doses (48 hours)	Two 186 mg capsules (372 mg) orally once daily	2 capsules per day
74.5 mg capsules	Five 74.5 mg capsules (372 mg) orally every 8 hours for 6 doses (48 hours)	Five 74.5 mg capsules (372 mg) orally once daily	5 capsules per day

*Start maintenance doses 12 to 24 hours after the last loading dose

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Recommended Dosage in Pediatric Patients:

<u>Dosage Form</u>	<u>Age</u>	<u>Body Weight (kg)</u>	<u>Loading Dose</u>	<u>Maintenance Dose*</u>	<u>Maximum Quantity Limit</u>
74.5 mg capsules	6 to < 18 years of age	16 kg to < 18 kg	Two capsules (149 mg) orally every 8 hours for 6 doses (48 hours)	Two capsules (149 mg) orally once daily	5 capsules per day
		18 kg to < 25 kg	Three capsules (223.5 mg) orally every 8 hours for 6 doses (48 hours)	Three capsules (223.5 mg) orally once daily	
		25 kg to < 32 kg	Four capsules (298 mg) orally every 8 hours for 6 doses (48 hours)	Four capsules (298 mg) orally once daily	
		≥ 32 kg	Five 74.5 mg capsules (372 mg) orally every 8 hours for 6 doses (48 hours)	Five 74.5 mg capsules (372 mg) orally once daily	

*Start maintenance doses 12 to 24 hours after the last loading dose

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 weeks

- Member is 6 years of age or older and weighs 16 kg or greater
- Member must meet **ONE** of the following:
 - Member has a diagnosis of invasive aspergillosis, and the member has a documented trial and failure, or contraindication, to voriconazole therapy as first line therapy
 - Member has a diagnosis of invasive mucormycosis
 - Member is completing a course of therapy that has been initiated in the hospital

Please provider date therapy was initiated (loading dose included) and how many days completed:

DATE: _____ **DAYS OF THERAPY COMPLETED:** _____

- Provider confirms the member is **NOT** on concurrent use of strong CYP3A4 inducers such as rifampin, carbamazepine, or St. John's Wort

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- Provider confirms the member is **NOT** on concurrent use of strong CYP3A4 inhibitors such as ketoconazole or high dose ritonavir
- Provider confirms the member does **NOT** have medical history of familial short QT syndrome

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 meet all initial authorization criteria
- Member will require secondary prophylaxis to prevent disease recurrence of invasive aspergillosis or mucormycosis
- Liver function tests are being monitored, and the member is **NOT** experiencing clinical signs and symptoms of liver disease or hepatic failure

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.****