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: Xphozah® (tenapanor)

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:** _____

Quantity Limit: 2 tablets per day

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
- ❑ Prescribed by or in consultation with a nephrologist
- ❑ Member has chronic kidney disease **AND** has been on maintenance dialysis for at least 3 months
- ❑ Provider has submitted member's baseline serum phosphate level: _____
- ❑ Member's serum phosphate level at baseline and is ≥ 5.5 mg/dL

(Continued on next page)

- ❑ Requested medication is prescribed as add-on therapy to phosphate binder therapy
- ❑ Member has had an inadequate response and/or intolerance or contraindication to at least **TWO (2)** phosphate binders prescribed as monotherapy (e.g., sevelamer, lanthanum, ferric citrate, sucroferric oxyhydroxide, calcium carbonate, and calcium acetate). **NOTE: Treatment failure is defined as serum phosphorus level remains > 5.5 mg/dL after 30 days of therapy with a phosphate binder (verified by chart notes and/or pharmacy paid claims)**
- ❑ Member does **NOT** have known or suspected mechanical gastrointestinal obstruction

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 has experienced a positive clinical response to therapy (e.g., reduction in serum phosphorus from pretreatment level, maintenance of serum phosphorus level ≤ 5.5 mg/dL) and continues to require use with requested medication
- ❑ Requested medication is prescribed as add-on therapy to phosphate binder therapy

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.*****

***Approved by Pharmacy and Therapeutics Committee: 1/18/2024**
REVISED/UPDATED/REFORMATTED: 2/16/2024