

# 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.**

**Drug Requested:** flucytosine (Ancobon) capsules

**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:** 25 mg/kg/dose every 6 hours

**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 has a diagnosis of **ONE** of the following:
  - Documented diagnosis of cryptococcal meningitis
  - Documented diagnosis of candida endocarditis
  - Documented diagnosis of a cryptococcal pulmonary infection **AND** documentation of clinical inappropriateness/resistance/treatment failure with at least one first-line agent (e.g., fluconazole, itraconazole, or voriconazole)

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- ❑ Documented diagnosis of candida septicemia **AND** documentation of clinical inappropriateness/resistance/treatment failure with at least one first-line agent (e.g., fluconazole, voriconazole)
- ❑ Documented diagnosis of candiduria **AND** documentation of clinical inappropriateness/resistance/treatment failure with fluconazole

*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.\**