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: Pharmacy Benefit Oncology Medications

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:** _____

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

- ❑ The requesting provider is an oncologist

AND

- ❑ Use of the requested oncology therapy is documented in literature and found in **ONE** of following **(please ensure diagnosis is documented above)**:
  - ❑ FDA labeling – in accordance with a specific indication

OR

Accepted off-label indication found in the most recent edition of any of the following:

- ❑ American Hospital Formulary Service Drug Information
- ❑ National Comprehensive Cancer Network's Drugs & Biologics Compendium
- ❑ Elsevier Gold Standard's Clinical Pharmacology

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OR

- ❑ For medical necessity **(Please provide clinical rationale and submit any chart notes/literature you feel would be pertinent in support of medical necessity. Note: experimental/investigational use as defined by the chemotherapy administration policy precludes medical necessity.)**

_____

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AND

- ❑ **If a biomarker/genetic component is required for the drug's site of action please ensure the following:**
  - ❑ Submit/attach all genetic mutation, receptor, biomarker, laboratory documentation using an FDA-approved test including both the results and which test was utilized

    NOTE: Experimental/investigational use as defined by the chemotherapy administration policy precludes medical necessity

AND

- ❑ Member has tried and failed current treatment-guideline and FDA label-recommended first-line agents [or has a documented intolerance, FDA-labeled contraindication, or hypersensitivity to first line therapies]

AND

- ❑ Please list all previous chemotherapy regimens and dates **(please attach chart notes)**

Chemotherapy Regimen	Dates/Cycles Completed
1.	
2.	
3.	
4.	

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AND

- ❑ Requested dose must meet **ONE** of the following:
  - ❑ The quantity (dose) requested is in accordance with FDA approved labeling, and if applicable or necessary, age and weight conditions are met
    - What is the quantity requested per DAY? _____

OR

  - ❑ The quantity (dose) requested is higher than the maximum dose recommendation found in FDA approved labeling (i.e., the package insert), and the prescriber has submitted clinical literature and medical documentation in support of the safety and efficacy of the higher dose (such as evidence from practice guidelines or clinical trials from peer-reviewed medical literature)

    **** Please note: Chart documentation of the above is required to be submitted along with this request ****

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AND

- ❑ If requesting Kisqali® (ribociclib) for advanced or metastatic hormone receptor-positive, HER2-negative breast cancer, member must have trial and failure of **ONE** of the following **(verified by chart notes or pharmacy paid claims)**:
  - ❑ Ibrance® (palbociclib)
  - ❑ Verzenio® (abemaciclib)

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 is currently receiving the requested agent **(please submit medical chart notes and documentation of therapy history)**

AND

- ❑ Member requires continuation of therapy and is **NOT** experiencing disease progression

AND

- ❑ Ongoing treatment is consistent with FDA-labeling or compendia support

AND

- ❑ Member is **NOT** experiencing an FDA-labeled limitation of use or toxicity

AND

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- ❑ The quantity (dose) requested is in accordance with FDA approved labeling
  - **IF** there is an adjustment in quantity (dose) requested, higher than the maximum dose recommendation in FDA-approved labeling (i.e., the package insert), the prescriber must submit clinical literature and medical documentation in support the safety and efficacy of the higher dose (such as evidence from practice guidelines or clinical trials from peer-reviewed medical literature).

    **** Please note: Chart documentation of the above is required to be submitted along with this request ****

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Medication being provided by Specialty Pharmacy – Proprium Rx

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**: 11/16/2020; 5/25/2023
REVISED/UPDATED: ~~12/7/2020~~; 11/08/2021; 11/22/2021; ~~6/26/2023;~~ **1/22/2024**