SENTARA COMMUNITY PLAN
(MEDICAID)
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 will be delayed.**

Drug Requested: Bronchitol® (mannitol)

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 Approval: 1 (ONE) year

1. Is the prescriber a pulmonologist or in consultation with a pulmonologist? **AND** ❑ Yes ❑ No
2. Is the member 18 years of age or older? **AND** ❑ Yes ❑ No
3. Does the member have a diagnosis of cystic fibrosis (CF)? **AND** ❑ Yes ❑ No
4. Is there confirmation that Bronchitol® will be used as add-on maintenance therapy to improve pulmonary function? **AND** ❑ Yes ❑ No

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5. Has the member passed the Bronchitol Tolerance Test (BTT)? **AND** ❑ Yes ❑ No
6. Is there confirmation that the member does **NOT** have bronchospasm? **AND** ❑ Yes ❑ No
7. Is there confirmation that the member does **NOT** have significant hemoptysis (volume greater than 60 mLin the previous 3 months)? ❑ Yes ❑ No

Renewal Approval – 1 (ONE) year

1. Does the member continue to meet the above criteria? **AND** ❑ Yes ❑ No
2. Has the member experienced symptom improvement (e.g., pulmonary function [FEV1 improvement])? ❑ Yes ❑ No

Medication being provided by a Specialty Pharmacy - PropriumRx

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.

***REVISED/REFORMATTED/UPDATED:** ~~8/11/2021;09/20/2022;~~ **11/8/2023**