Sentara Health Plans

Would you like to use electronic prior authoriztion? Consider using Surescripts, our electronic prior authorization portal at providerportal.surescripts.net/ProviderPortal/login OR fax completed prior authorization request form to 800-750-9692.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at sentarahealthplans.com/en/providers/authorizations/prescription-drugs

Verzenio (Medicare)

REQUIRED: Office notes, labs, and medical testing relevant to request showing medical justification to support diagnosis

Member Information

Member Name (first & last):	Date of Birth:	Gender: ☐Male ☐Female	Height:
Member ID:	City:	State:	Weight:

Prescribing Provider Information

Requestor's Name:	Requestor's Phone Number:	Requestor's Fax Number:	
Provider Name (first & last):	Specialty	NPI:	DEA:
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone:	Office Fax:	

Dispensing Provider/Pharmacy Information

Place of Administration:	☐Self-Administered ☐Physician's Office ☐Home ☐Home Infusion Center ☐Outpatient Infusion Center Name: _____

Agency NPI:	Agency Name:	Agency Phone Number:
Agency Address		Agency Fax Number:
City:	State:	Zip:

Dispensing Location:	☐Retail Pharmacy ☐Mail Order ☐Physician's Office ☐Specialty Pharmacy ☐Other

Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:
Pharmacy NPI:		

Requested Medication Information

Medication request is NOT for an FDA approved, or compendia-supported diagnosis (check one): ☐Yes ☐No	Diagnosis:	ICD-10 Code:
Are there any contraindications to formulary medications? If yes, please specify:	Is this a New Request or Continuation of Therapy: ☐New, start date: __/__/_____ ☐Continuation, date of last treatment: __/__/_____	
Directions for Use:	Strength:	Dosage Form
	Duration:	Quantity: / Days Supply:

What medication(s) has the member tried and failed for this diagnosis? Please specify below including duration of treatment.

Turn-Around Time for Review:

☐Standard ☐Urgent: Waiting standard time for decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision.

Signature: _____

Sentara Health Plans Member First Name: _____ Member Last Name: _____

Member ID: _____ Member Date of Birth: _____

Clinical Information:

** Indicate questions that are required to be answered*

Q1. Please select appropriate diagnosis:

☐ Breast Cancer ☐ Other

Q2. For Reauthorization: Has the member responded positively to therapy as determined by the prescribing physician?

☐ Yes ☐ No

Q3. For all diagnoses: Is the member's disease hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative as detected by an FDA-approved test?

☐ Yes ☐ No

Q4. For all diagnoses: Does the member's disease meet any of the following:

☐ Member has early breast cancer that is node-positive at high risk of recurrence (e.g. members with greater than or equal to 4 positive lymph nodes or 1-3 positive lymph nodes with one or more of the following: Grade 3 disease or tumor size greater than or equal to 5 cm) and will be using the requested medication in combination with endocrine therapy (i.e. anastrozole, exemestane)

☐ Member has advanced or metastatic disease and will be using the requested medication in combination with an aromatase inhibitor (i.e. letrozole, anastrozole) as initial endocrine therapy

☐ Member has advanced or metastatic disease progression following endocrine therapy and will be using the requested medication in combination with fulvestrant

☐ Member has advanced or metastatic disease progression following endocrine therapy and prior chemotherapy in the metastatic setting. Requested medication will be used as monotherapy

☐ None of the above