SENTARA COMMUNITY PLAN
(MEDICAID)

NON-PREFERRED DRUG REQUEST FORM FOR MEDICAL NECESSITY

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.**

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:** ____________

PRESCRIPTION/MEDICAL HISTORY: List previous alternative medications that have been utilized

Medication Name	Dose	Length of Trial	Outcome
1. ________	________	________	________
2. ________	________	________	________
3. ________	________	________	________
4. ________	________	________	________

(Continued on next page)

CLINICAL CRITERIA/MEDICAL NECESSITY: Provide clinical evidence that the **PREFERRED** drug(s) will not provide adequate benefit. Attach chart notes.

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*****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.****