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

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

☐ Yes ☐ No

Q2. Please select applicable diagnosis: *

☐ Crohn's Disease (CD)
☐ Plaque Psoriasis (PsO)
☐ Psoriatic Arthritis (PsA)
☐ Ulcerative Colitis (UC)
☐ Other

Q3. For all diagnoses: Will the medication be used concomitantly with other biologics or targeted synthetic DMARDs?

☐ Yes ☐ No

Q4. For all diagnoses: Has the medication been prescribed by or in consultation with one of the following:

☐ PsA: Rheumatologist or dermatologist
☐ PsO: Dermatologist
☐ UC/CD: Gastroenterologist
☐ None of the above

Q5. For all diagnoses: Does the member have moderately to severely active disease?

☐ Yes ☐ No

Q6. For CD/UC: Has the member received a single IV loading dose within three months of initiating therapy with the requested medication?

☐ Yes ☐ No

Q7. For CD: Does the member have evidence of large or deep ulcers, strictures, or extensive areas of disease and/or evidence of stricturing, penetrating, or perianal disease on endoscopy?

☐ Yes ☐ No

Q8. For UC: Which of the following does the member have:

☐ Member presents with frequent, bloody stools that occur 6 or more times daily or frequent and heavy rectal bleeding
☐ Member has severe inflammation or ulcers as visualized on endoscopy
☐ None of the above

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Member First Name: _____ Member Last Name: _____

Member ID: _____ Member Date of Birth: _____

Q9. For PsA: Has documentation been sent showing the presence of at least one of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, active skin or nail involvement, or extraarticular manifestations such as uveitis or inflammatory bowel disease (IBD)?

☐ Yes ☐ No