



Would you like to use electronic prior authorization? Consider using Surescripts, our electronic prior authorization portal at providerportal.surescripts.net/ProviderPortal/login OR fax completed 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

Medical Necessity General Form

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									
Drug Name, Strength, Dosage Form (i.e. Lisinopril 10 mg tablets):					Directions for use:				
					Duration:		Quantity:		Days Supply:
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: ____/____/____				
Medication request is NOT for an FDA approved, or compendia-supported diagnosis (check one): ☐ Yes ☐ No					Diagnosis:		ICD-10 Code:		
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: _____									

Member First Name: _____ Member Last Name: _____

Member ID: _____ Member Date of Birth: _____

Clinical Information:

1. For reauthorization: has the member responded positively to therapy as determined by the prescribing physician?

☐ YES ☐ NO

2. Does the patient have a clinical condition for which other alternatives are not recommended based on published guidelines or clinical literature?

If so, please provide documentation: _____

3. Are additional risk factors (e.g., GI risk, cardiovascular risk, age) present? If so, please provide risk factors: _____

4. Has the condition been confirmed by diagnostic testing? If so, please provide diagnostic test and date: _____

5. Provider acknowledges the following policies of the health plan:

All documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.
Previous therapies will be verified through pharmacy paid claims or submitted chart notes. Use of samples to initiate therapy does not meet step edit/preauthorization criteria.

☐ YES ☐ NO