



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 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

Qinlock (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: <input type="checkbox"/> Male <input type="checkbox"/> 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:		<input type="checkbox"/> Self-Administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Home <input type="checkbox"/> Home Infusion Center <input type="checkbox"/> Outpatient Infusion Center Name: _____							
Agency NPI:			Agency Name:			Agency Phone Number:			
Agency Address						Agency Fax Number:			
City:					State:		Zip:		
Dispensing Location:		<input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Mail Order <input type="checkbox"/> Physician's Office <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> 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): <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> New, start date: __/__/____ <input type="checkbox"/> 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:									
<input type="checkbox"/> Standard <input type="checkbox"/> 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: _____									



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: *

☐ Gastrointestinal Stromal Tumor (GIST)

☐ Other

Q3. For GIST: Will the medication be used as monotherapy?

☐ Yes

☐ No

Q4. For GIST: Is the member's disease considered advanced?

☐ Yes

☐ No