



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:
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: _____				



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: *

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