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

## 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<br>☐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?<br>If yes, please specify: | Is this a New Request or Continuation of Therapy:<br>☐New, start date: __/__/_____<br>☐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:**

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