SENTARA HEALTH PLANS

MAXIMUM DAILY DOSAGE LIMIT EXCEPTIONS REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: ____

Member Sentara #: ______________________________ **Date of Birth:** ____________

Prescriber Name: ____

Prescriber Signature: ______________________________ **Date:** ____________

Office Contact Name: ____

Phone Number: ____________________________ **Fax Number:** ____________________

DEA OR NPI #: ____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: ____

Dosing Schedule: ____________________________ **Length of Therapy**: ____________________

Diagnosis: ____________________________ **ICD Code, if applicable:** ________________

Weight: ____________________________ **Date:** ____________________________

❑ **Newly Prescribed Therapy** **OR** ❑ **Refill Therapy**

Dosing Instructions: ____

Anticipated duration of therapy: ____________________ **Quantity per 30 Day Supply**: ____________

Diagnosis for this Drug or ICD Code: ____

If diagnosis is pain, is this cancer pain? ____

Reason for Request: ____

Other Medications Currently Used in Combination with the Requested Medication for the Treatment of this Diagnosis:

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(Continued on next page)

Therapies Tried: ____

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Is the prescribed dose higher than the maximum dose recommendation in FDA-approved labeling (i.e., the package insert)? ❑ Yes ❑ No

If **Yes,** please provide documentation to support the safety and efficacy of the higher dose (such as evidence from practice guidelines or clinical trials from peer-reviewed medical literature). **(Attach additional pages if necessary.)**

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Use of samples to initiate therapy does not meet step-edit/preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.