PRIOR AUTHORIZATION REQUEST FORM

Medical Necessity/Non-Formulary

Phone:800-727-7536 Fax back to: 833-770-7569

Sentara manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:**	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, state, ZIP:	City, state, ZIP:	
Member Phone:		
Drug name:	☐ Expedited/Urgent	
Directions/SIG:		

Q1. What is the diagnosis for which the medication is being prescribed?

Q2. Please list any previous medication therapies trialed and failed (Name, Dose, Length of Trial).

Q3. Has the patient failed previous treatment and shown intolerance, or has a contraindication to the covered alternatives?

☐ Yes ☐ No

Q4. If YES, describe and attach chart notes

_____ _____

Physician Signature **Date**

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Q5. Has the appropriate documentation and/or supporting lab values for the medication being requested been attached to this PA form?

☐ Yes ☐ No

Q6. Is the medication being requested for an off label non-FDA approved indication? If so, please provide appropriate supporting compendia.

☐ Yes ☐ No

_____ _____

Physician Signature **Date**