

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:



EnvisionRxOptions General Prior Authorization Form

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign:

Q1. Please indicate the patient's diagnosis below

Q2. Have other formulary alternatives in this drug category/class been tried and failed?

Yes No

Q3. Please list them below along with the date the medication was tried and failed

Q4. If the patient is unable to tolerate the formulary alternative, what is the issue the patient is having?

Q5. For medical necessity reviews, you must provide a unique peer-reviewed journal article to support your request for off-label use. Please attach any medical information that may support approval

Q6. Please provide any supporting clinical statements (such as lab values, adverse outcomes, treatment failures, or any other additional clinical information to support a formulary exception request)

Physician Signature

Date