MEDICATION PRIOR AUTHORIZATION REQUEST FORM
SILVERSUMMIT HEALTHPLAN - NEVADA

*** Do Not Use This Form for Biopharmaceutical Products ***

FAX this completed form to (866) 399-0929

OR Mail requests to: Envolve Pharmacy Solutions PA Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720
Call (866) 716-5099 to request a 72-hour supply of medication

I. PROVIDER INFORMATION	II. MEMBER INFORMATION
Prescriber name (print):	Member name:
Office contact name:	Identification number:
NPI:	Group number:
Fax:	Date of Birth:
Phone:	Medication allergies:

III. DRUG INFORMATION (One drug request per form)

Drug name and strength:	Dosage form:	Dosage Interval (sig)	Qty per Day:

Diagnosis relevant to ***this*** request:

Expected length of therapy:

Medication History for this Diagnosis

A. Is member currently treated on this medication?
❑ yes; How Long?_____ [go to item B] ❑no [skip items B & C; go to item D]

B. Is this request for continuation of a previous approval?
❑yes [go to item C] ❑no [skip item C; go to item D]

C. Has strength, dosage, or quantity required per day increased or decreased?
❑ yes [go to item D] ❑no [skip item D; indicate rationale for continuation in Section IV and submit form]

D. Please indicate previous treatment and outcomes below.

Drug Name (include strength and dosage)	Dates of Therapy	Reason for Discontinuation
1		
2		
3		
4		

NOTE: Confirmation of use will be made from member history on file; prior use of preferred drugs is a part of the exception criteria. **SilverSummit HealthPlan Preferred Drug List (PDL)** is available on the **SilverSummit HealthPlan** website at www.SilverSummitHealthPlan.com.

IV. RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION (Required for all Prior Authorizations)

Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	Provider Signature:	Date:

Envolve Pharmacy Solutions will respond via fax or phone within 24 hours of receipt of the request. Requests for prior authorization must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)