

TYPE OF SPECIALTY MEDICATION REQUEST. PLEASE SELECT ONE OPTION.

***Note: If requesting a self-injectable, fax completed form to (855) 678-6976;*

OR Envolve Pharmacy Solutions Prior Authorization Department, 5 River Park Place East, Suite 210 Fresno, CA 93720

<input type="checkbox"/> **Self-Injectable and home infusions	Fax Completed form to 855-678-6976
<input type="checkbox"/> Buy and Bill	Call Pre-Cert Dept. at (844)366-2880 or fax to (844)367-7022

Patient Information **Physician Information**

Patient Name			Physician Name		
Address			State Lic	DEA #	
City	State	Zip	NPI	Specialty	
Home Phone			Practice/Hospital		
Cell Phone			Address		
SSN	Allergies		City	State	Zip
DOB	Sex		Phone	Fax	
Weight	<input type="checkbox"/> lbs <input type="checkbox"/> kg	Height	BSA	m ²	
			Nurse / Key Contact		

INSURANCE INFORMATION (Complete or Attach Copies of Cards)

Primary Insurance		Secondary Insurance		RX Card (PBM)	Cardholder First Name
City	State	City	State	PBM BIN	Last Name
Plan #		Plan #		Plan #	Employer
Group #		Group #		Group #	ID #
Phone		Phone		Phone	Group #

DIAGNOSIS (Required)

What is the ICD-9/ICD-10/Code:

Medication	Strength	Directions	Quantity	Refills

PATIENT EVALUATION

- Is the member currently treated with this medication?
 Yes; (please continue to next question) No; (please move on to question #4)
- How long has the patient been on treatment with this medication: _____ years months
- Has the patient had a positive outcome? Yes No
- Please indicate previous treatments and outcomes:

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

Note: Confirmation will also be made from member history on file when possible; prior use of preferred drugs is part of exception criteria

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.	Physician Signature:	Date:
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