PRIOR AUTHORIZATION REQUEST FORM FOR SPECIALTY PRESCRIPTION MEDICATIONS

silversummit healthplan

envolve Pharmacy Solutions

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*	
❑**Self-Injectable and home infusions	Fax Completed form to (833) 645-2736
❑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 ❑lbs❑ 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

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

Drug Name (include strength and dosage)	Dates of Therapy	Reason for Discontinuation
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:

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.)