PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

EnvisionRx General Prior Authorization- 1

Phone: 844-348-9612 Fax back to: 866-414-3453

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:	**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:

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

Q1. Is this request for initial or continuing therapy?

- Initial therapy
- Continuing therapy (Start date MM/YY):

Q2. Please indicate the patient's diagnosis for the requested medication:

Q3. What is the quantity of medication that is being requested per 30 days?

Q4. What is the anticipated duration of therapy?

- Less than one month
- One to three months
- Three months to one year
- Lifetime

Q5. Please list all other medications the patient has previously tried for the indicated diagnosis along with the dates and outcomes (e.g. ineffective, adverse reaction, etc):

Q6. IF THE REQUEST IS FOR OFF-LABEL USE you must provide a unique peer-reviewed journal article to support the request. Please attach any medical information that may support approval.

Physician Signature

Date

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