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 855-678-6976
❑Buy and Bill	Call Pre-Cert Dept. at (888)990-5702 or fax to (888) 790-0276
❑Replacement (Delivered to MD office or facility)	Call Pre-Cert Dept. at (888)990-5702 or fax to (888) 790-0276

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.)