# PRIOR AUTHORIZATION REQUEST FORM

**EOC ID:**

**AgeWell Standard NFE Request**

**Phone: 866-250-2005 Fax back to: 877-503-7231**

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

Continuing Therapy - Start date:

Q2. Please provide the diagnosis for which the requested medication is being prescribed:

Q3. Please list the medication(s) used to treat the diagnosis listed above, for which the patient has experienced an inadequate response, intolerance, contraindication, drug-drug interaction, or an allergy to therapy. Please specify all drug names and describe the inadequate response, intolerance, contraindication, drug-drug interaction, or allergy to treatment for each one below:

Medication 1 (please specify/describe):

Medication 2 (please specify/describe):

Medication 3 (please specify/describe):

Medication 4 (please specify/describe):

Q4. Prescriber may provide any supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other additional clinical information to support this request):

**Physician Signature** **Date**