PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

AgeWell Tier Exception 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? If continuing therapy, please include treatment start date.

Initial

Continuing Therapy - Start Date:

Q2. Please provide the diagnosis for the requested medication:

Q3. Please list medications previously tried and failed:

Q4. Which of the following apply to the patient requesting the tiering exception? If one or more of the following applies to the patient, please also complete question 6.

The generic or preferred brand alternatives would not be as effective or have not been as effective to treat this diagnosis.

The patient was intolerant of the generic or preferred brand alternatives to treat this diagnosis.

The patient has a documented allergy to the generic or preferred brand alternatives to treat this diagnosis.

Q5. Please provide any supporting clinical statements (e.g chart notes, lab values, adverse outcomes, treatment failures, or any other additional clinical information to support a tier exception):

Physician Signature **Date**