PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

EnvisionRxOptions General Prior Auth Form

Phone: 855-872-0005 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. Please indicate the patient's diagnosis below
Q2. For medical necessity reviews, you must provide a unique peer-reviewed journal article to support your request for off-label use. Please attach any medical information that may support approval
Q3. Please provide any supporting clinical statements (such as lab values, adverse outcomes, treatment failures, or any other additional clinical information to support a formulary exception request)

Physician Signature **Date**

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