PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

VPHP General Prior Authorization

Phone: 855-872-0005 Fax back to: 866-754-9616

EnvisionRx 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/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

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

Q1. This is a general prior authorization form, to receive a DRUG SPECIFIC PA FORM for Virginia Premier, please call 866-250-2005, or utilize Cover My Meds electronic PA submission if capable, or visit PromptPA at https://envision.promptpa.com/ .
Q2. Is this request for initial or continuing therapy? ☐ Initial therapy ☐ Continuing therapy (Start date MM/YY):
Q3. Please indicate the patient's diagnosis for the requested medication:
Q4. Please list any medications the patient has tried and failed that are applicable to this request:
Q5. 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.
Q6. Please submit chart notes/medical records for the patient that are applicable to this request
Q7. Virginia Premier does not recognize the use of drug samples to meet clinical criteria requirements for prior drug

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use for drugs covered under the pharmacy benefit or drugs administered in the physician office or other outpatient setting. A physician's statement that samples have been used cannot be used as documentation of prior drug use. Do you attest that you have read and understand this statement and are not indicating sample usage as continuing therapy?

☐ Yes ☐ No

Prescriber Signature

Date