envolve Pharmacy Solutions

pa health & wellness

# Prior Authorization Request Form for Beta Agonist Bronchodilator

**FAX this completed form to (877) 386-4695**

**OR Mail requests to: Envolve Pharmacy Solutions PA Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720**

| I. PROVIDER INFORMATION | II. MEMBER INFORMATION |
|---|---|
| Prescriber Name: | Member Name: |
| Prescriber Specialty: | Identification #: |
| Office Contact Name: | Group #: |
| Group Name: | Date of Birth: |
| Fax #: | Medication Allergies: |
| Phone #: | |

**III. DRUG INFORMATION (One drug request per form)**

| Drug name and strength: | Dosage Interval (sig): | Qty. per Day: |
|---|---|---|
| | | |

**IV. REQUIRED DOCUMENTION *(Detailed medical record documentation demonstrating evidence for each item must be submitted with prior authorization request)***

Specify diagnosis & diagnosis code relevant to this request: Dx/Dx Code: _____

- ☐ If requesting for daily quantity exceeding daily limit (Refer to https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx), please provide supporting information:_____

**Therapeutic Duplication:**

If concurrently prescribed a therapeutic duplicate (i.e. another beta agonist bronchodilator or dose different from the agent being requested):

- ☐ is being transitioned from one beta agonist bronchodilator to another with the intent of discontinuing one of the medications
- ☐ has a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines

***SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.***

**INITIAL REQUESTS:**

- ☐ For non-preferred short-acting inhaled beta agonist bronchodilators, does the member have a history of trial and failure of or contraindication or intolerance to the preferred short-acting inhaled beta agonist bronchodilators? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.*
- ☐ For non-preferred long-acting inhaled beta agonist bronchodilators, does the member have a history of trial and failure of or contraindication or intolerance to the preferred long-acting inhaled beta agonist bronchodilators? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.*
- ☐ For non-preferred oral beta agonist bronchodilators, does the member have a history of trial and failure of or contraindication or intolerance to the preferred inhaled bronchodilators? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.*

**RENEWAL REQUESTS:**

- ☐ Documentation of tolerability and has experienced a positive clinical response to requested medication evidenced by:_____

**IV. ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION :**

| | | |
|---|---|---|
| Appropriate clinical information to support the request on the basis of medical necessity must be submitted. | Provider Signature: | Date: |

Envolve Pharmacy Solutions will respond via fax or phone within 24 hours.

Requests for prior authorization (PA) requests 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.)