

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 DOCUMENTATION (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: _____			
<input type="checkbox"/> Potential drug interactions addressed by the prescriber (such as discontinuation or dose reduction of interacting medication, or counseling the member of risks associated with the use of both medication) <input type="checkbox"/> Member does not have a history of a contraindication to the requested medication <input type="checkbox"/> 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: _____			
SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM. <input type="checkbox"/> Documented history of therapeutic failure to a low fermentable oligo-, di-, and monosaccharides and polyols (FODMAP) diet: _____ <input type="checkbox"/> Prescribed by or in consultation with a gastroenterologist			
RENEWAL REQUESTS: <input type="checkbox"/> Has the member experienced tolerability and a positive clinical response since starting requested medication as 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.)