General Specialty Medication PA Form

Prior Authorization Form

Date: _____ Date Medication Required:_____

CoverMyMeds is Envolve Pharmacy Solutions' preferred way to receive prior authorization requests. Visit CoverMyMeds.com/EPA/EnvolveRx to begin using this free service.
OR FAX this completed form to 1.877.386.4695 OR Mail requests to: Envolve Pharmacy Solutions PA Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720

Patient Information

Last Name:	First Name:	Middle:	DOB: ____/____/_____
Address:	City:	State:	Zip:
Daytime Phone:	Evening Phone:	Sex: ☐ Male ☐ Female	

Insurance Information (Attach copies of cards)

Primary Insurance:		Secondary Insurance:	
ID #	Group #	ID #	Group #
City:	State:	City:	State:

Physician Information

Name:	Specialty:	NPI:	
Address:	City:	State:	Zip:
Phone # ( )	Secure Fax #: ( )	Office contact:	

Primary Diagnosis

ICD-10 code: _____

Description in words: _____

Prescription Information

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS

Clinical Information ***** Please submit supporting clinical documentation*****

☐ **INITIAL THERAPY** ☐ **CONTINUATION OF THERAPY;** Therapy start date: _____

Note: This form is to be used to request review for Specialty Medication where there is no drug specific form. For non-specialty medication, please use Envolve Pharmacy Solutions Prior Authorization form.

Patient's weight: _____ kg Patient's height: _____ inches

1. Is the patient currently treated with this medication? ☐Yes ☐No
2. If continuation of therapy, how long has the patient been on treatment? _____ ☐ years ☐ months
3. Has the patient had a positive outcome? ☐Yes ☐No
4. Please indicate previous treatment and outcomes:

Drug Name (include strength and dosage)	Dates of Therapy	Reason for Discontinuation
1.		
2.		
3.		
4.		

Note: Confirmation of use will be made from member history on file or chart documentation of previously tried therapies; prior use of preferred drugs is part of the exception criteria.

5. Please state rationale for request / pertinent clinical information (**required for all prior authorizations**): _____

_____

_____

_____

Physician's Signature _____ **Date:** _____