

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: _____	
Does the member have a history of contraindication to the prescribed medication?		<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit documentation.</i>	
Requests for all non-preferred medications: Does the member have a history of trial and failure of or contraindication or intolerance to the preferred Antidepressant, other? Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.		<input type="checkbox"/> Yes <i>Submit documentation of previous trials/failures, contraindications, and/or intolerances or current use.</i> <input type="checkbox"/> No	
<input type="checkbox"/> Member has a current history (within past 90 days) of using the prescribed the requested non-preferred antidepressant, since: _____ <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: _____			
For Spravato: <input type="checkbox"/> Prescribed by or in consultation with a psychiatrist <input type="checkbox"/> Member does not have severe hepatic impairment (Child-Pugh class C)			
Therapeutic Duplication: If concurrently prescribed a therapeutic duplicate (i.e. antidepressant different from the agent being requested): <input type="checkbox"/> Member is transitioned from one antidepressant to another with the intent of discontinuing one of the medications; <input type="checkbox"/> Member 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: <input type="checkbox"/> Documented history of therapeutic failure, contraindication or intolerance to at least 2 of the following for at least 6 weeks: (medication, start date and end date) <input type="checkbox"/> Preferred Antidepressant, other: _____ <input type="checkbox"/> Antidepressant, SSRI: _____ <input type="checkbox"/> Augmentation therapy (e.g., lithium, antipsychotic, stimulant) in combination with an antidepressant: _____			
INITIAL REQUESTS FOR SPRAVATO: <input type="checkbox"/> Prescribed in conjunction with a therapeutic dose of an oral antidepressant: _____			

RENEWAL REQUESTS:

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

RENEWAL REQUESTS FOR SPRAVATO:

- ☐ Prescribed in conjunction with a therapeutic dose of an oral antidepressant: _____
- ☐ Member has an improvement in disease severity since initiating Spravato, 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.)