



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Actemra-1 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is the request a new start or continuation of current therapy?

New start

Continuation of current therapy/ Start date (MM/DD/YY):

Q2. Please indicate the patient's diagnosis:

Rheumatoid Arthritis (RA)

Polyarticular Juvenile Idiopathic Arthritis (JIA)

Systemic Juvenile Idiopathic Arthritis (JIA)

Other diagnosis (please complete question 3):

Q3. If diagnosis is OTHER, please specify:

Q4. If this request is for continuing therapy, has the patient's condition improved as a result of using Actemra?

Yes No Unknown

Q5. Prescriber may provide any supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other additional clinical information) to support an authorization request.

Q6. Does the patient have any active infection (including Tuberculosis)?

Yes No Unknown

Q7. Has the patient been screened for latent tuberculosis?

Yes No Unknown

Q8. Is the patient current receiving treatment for latent tuberculosis?

Yes No Unknown

Q9. Has the patient been screened for Hepatitis B or is undergoing treatment?

Yes No Unknown

Q10. Has the patient tried or is intolerant to a Tumor Necrosis Factor (TNF) agent? If so, please provide details



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Actemra-1 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Yes No Unknown

Q11. Please list all other medications the patient has previously tried for the indicated diagnosis along with the dates and outcomes (e.g. ineffective, adverse reaction, etc).

Q12. 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

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Acthar-1

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy

Initial therapy

Continuing therapy (Start date MM/YY):

Q2. Please indicate the diagnosis:

Acute exacerbations of multiple sclerosis

Infantile spasms

Ophthalmic disease

Rheumatic disorders

Serum sickness

Severe erythema multiforme and/or Stevens-Johnson syndrome

Symptomatic sarcoidosis

Systemic lupus erythematosus or systemic dermatomyositis

Other

Q3. If diagnosis is OTHER, please specify:

Q4. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Actimmune-1 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign>(* Mandatory Questions)

Q1. Is this request for initial or continuing therapy?

Initial therapy

Continuing therapy (Start Date MM/YY):

Q2. Please indicate the patient's diagnosis below: *

Chronic granulomatous disease

Malignant osteoporosis

Atopic Dermatitis

Other

Q3. If the diagnosis is OTHER, please specify:

Q4. 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.

Q5. Please list all other medications the patient has previously tried for the indicated diagnosis along with the dates and outcomes (e.g. ineffective, adverse reaction, etc).

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Adagen-2 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign: (* Mandatory Questions)

Q1. Is the request for initial or continuing therapy?

Initial therapy

Continuing therapy (Start date MM/YY):

Q2. Please indicate the diagnosis: *

Adenosine deaminase deficiency in patient with severe combined immunodeficiency disease (SCID)

Other (please complete Q3)

Q3. If the diagnosis is OTHER, please specify:

Q4. Does the patient have severe thrombocytopenia?

Yes No Unknown

Q5. Is the patient a suitable candidate for a bone marrow transplantation?

Yes No Unknown

Q6. Did the patient fail a bone marrow transplantation?

Yes No Unknown

Q7. Please list all other medications the patient has previously tried for the indicated diagnosis along with the dates and outcomes (e.g. ineffective, adverse reaction, etc)

Q8. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Adcirca-2 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial therapy

Continuing therapy (Start date MM/YY):

Q2. Please indicate the patient's diagnosis for the requested medication:

Pulmonary arterial hypertension (PAH) (World Health Organization group 1)

Other

Q3. If the patient's diagnosis is OTHER, please specify:

Q4. Has the diagnosis been confirmed by right heart catheterization?

Yes No

Q5. Is the patient currently on nitrate therapy?

Yes No

Q6. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Aldurazyme-2 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial therapy

Continuing (Start date MM/YY):

Q2. Please indicate the patient's diagnosis for the requested medication:

Hurler or Hurler-Scheie form of mucopolysaccharidosis I (MPS I)

Scheie form of MPS I in a patient with moderate-to-severe symptoms

Other

Q3. If the patient's diagnosis is OTHER, please specify:

Q4. Please indicate which of the following diagnostic methods have been utilized to confirm diagnosis of Mucopolysaccharidosis:

Measurement of alpha-L-iduronidase activity

DNA Testing

None of the above

Q5. For Scheie form of MPS I, does the patient have at least 2 moderate to severe symptoms?

Yes No

Q6. Please list all other medications the patient has previously tried for the indicated diagnosis along with the dates and outcomes (e.g. ineffective, adverse reaction, etc)

Q7. FOR CONTINUING THERAPY, has the patient received at least 26 weeks of therapy with Aldurazyme and demonstrated improvement in lung function?

Yes No

Q8. 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.



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Aldurazyme-2 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

--	--

Physician Signature

Date

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document.



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Alpha-1 Proteinase Inhibitor-1 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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: Member Number: Date of Birth: Group Number: Address: City, State, Zip: Member Phone: Prescriber Name: Fax: Office Contact: NPI: Address: City, State, Zip: Phone: State Lic ID:

Drug Name: Expedited/Urgent

Directions:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign: Q1. Is the request for initial or continuing therapy? Q2. Please indicate the diagnosis for the requested medication: Q3. For diagnosis OTHER, Please Specify: Q4. Is the patient 18 years of age or older? Q5. Is the alpha1-proteinase inhibitor concentration is less than 11 micromoles per liter? Q6. Is the patient's FEV1 level is between 35% and 60% predicted? Q7. If the patient's FEV1 level is greater than 60% predicted, has the patient experienced a rapid decline in lung function (ie, reduction of FEV1 more than 120 mL/year) that warrants treatment? Q8. Does the patient have IgA deficiency with antibodies against IgA? Q9. Please provide any supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other additional clinical information to support an authorization request)

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Amphetamines- 1 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign>(* Mandatory Questions)

Q1. Is request for initial or continuing therapy?

Initial

Continuing (Start date MM/YY):

Q2. Please indicate the patient's diagnosis: *

Attention DeficitHyperactivity Disorder (ADHD)

Narcolepsy

Other

Q3. If the patient's diagnosis is OTHER, please specify:

Q4. Is the patient 3 years of age or older?

Yes No

Q5. Is the patient currently taking or has the patient taken a monoamine oxidase inhibitor (MAOI) within the last 14 days?

Yes No

Q6. Is the prescriber a psychiatrist?

Yes No

Q7. If request is for NARCOLEPSY, please submit sleep studies.

Q8. Do the benefits of use outweigh the potential risks of serious cardiovascular events?

Yes No

Q9. Prescriber may provide any supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other additional clinical information) to support an authorization request.

Q10. 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.



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Amphetamines- 1 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

--	--

Physician Signature

Date

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document.



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Anabolic Steroids- 1 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for new therapy or continuing therapy?

New therapy Continuing therapy

Q2. What is the diagnosis?

Suspected carcinoma of the prostate or breast (in male patient)

Carcinoma of the breast in women with hypercalcemia, pregnancy or nephrosis

OTHER

Q3. If diagnosis is OTHER, please provide additional information

Q4. Please list all other medications the patient has previously tried for the indicated diagnosis along with the dates and outcomes (e.g. ineffective, adverse reaction, etc)

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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Arcalyst-2 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial therapy

Continuing therapy (Start date MM/YY):

Q2. Please indicate the patient's diagnosis for the requested medication:

Cryopyrin-associated periodic syndromes (including familial cold autoinflammatory syndrome and Muckle-Wells syndrome)

Other

Q3. If the patient's diagnosis is OTHER, please specify:

Q4. Is the patient 12 years of age or older?

Yes No

Q5. Does the patient have any of the following (please select all that apply)?

Active infection

Chronic infection

Concurrent therapy with other biologics

None of the above

Q6. FOR CONTINUING THERAPY, has the patient's condition improved or stabilized?

Yes No

Q7. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Bosulif-2

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial therapy

Continuing therapy (Start date MM/YY):

Q2. Please indicate the patient's diagnosis below:

Chronic, accelerated, or blast phase Philadelphia chromosome-positive (Ph+) chronic myeloid leukemia (CML)

Other (please specify):

Q3. Has the patient tried and failed imatinib (Gleevec)?

Yes No

Q4. Has the patient tried and failed dasatinib (Sprycel)?

Yes No

Q5. REQUIRED INFORMATION: The physician must submit a hepatic panel, complete blood count (CBC), and documentation of 90 day response to Gleevec or Sprycel along with this request. Have these been included (please check the box ONLY if included with this request)?

CBC

Hepatic Panel

Documentation of 90 day response to Gleevec or Sprycel

None of the above

Q6. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

BotulinumToxins-1 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is the request for initial or continuing therapy?

Initial Continuing

Q2. Please indicate the patient's diagnosis:

Blepharospasm

Cervical dystonia

Overactive bladder (OAB) with symptoms of urge urinary incontinence, urgency, frequency OR Urinary Incontinence (detrusor overactivity) associated with a neurologic condition

Primary Axillary Hyperhidrosis (despite trial of topical agents)

Spasmodic torticollis

Strabismus

Upper limb spasticity (increased muscle tone in elbow flexors, wrist flexors, finger flexors, and thumb flexors)

Chronic migraines (>15 migraines per month and headaches lasting >4 hours a day)

Cosmetic use

Other (please specify):

Q3. If diagnosis is "OTHER", please provide details

Q4. For CONTINUING THERAPY, has there been at least a 50% reduction in headache frequency since starting therapy

Yes (please describe the response to therapy):

No

Q5. If use is for migraine, has the patient tried at least 8 weeks of oral migraine preventive therapy, unless it was contraindicated or not tolerated?

Yes No Unknown

Q6. Please provide any supporting clinical statements (such as lab values, adverse outcomes, treatment failures, or anyother additional clinical information to support a formulary exception request).



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

BotulinumToxins-1 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Q7. IF THE REQUEST IS FOR OFF-LABEL USE you must provide a unique peer-reviewed journal article to support therequest. Please attach any medical information that may support approval.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Buprenorphine-1 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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: Member Number: Date of Birth: Group Number: Address: City, State, Zip: Member Phone: Prescriber Name: Fax: Office Contact: NPI: Address: City, State, Zip: Phone: State Lic ID:

Drug Name: Expedited/Urgent

Directions:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign: Q1. Is the request for initial or continuing therapy? Q2. Please indicate which medication is being requested below: Q3. Please indicate the patient's diagnosis below: Q4. If the patient's diagnosis is OTHER, please specify: Q5. Is the member 16 years of age or older? Q6. Is the member receiving other Opioids? Q7. Is the member Male or Female? Q8. If the member is FEMALE: Is the member pregnant? Q9. Is the prescriber certified through the Substance Abuse and Mental Health Services Administration (SAMHSA) to prescribe Suboxone or Subutex?



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Buprenorphine-1 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Q10. Is treatment with Buprenorphine or Buprenorphine-Naloxone part of an overall treatment program?

Yes No

Q11. Is the patient being monitored periodically?

Yes No

Q12. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Cayston- 2 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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, Member Number, Date of Birth, Group Number, Address, City, State, Zip, Member Phone, Prescriber Name, Fax, Office Contact, NPI, Address, City, State, Zip, Phone, State Lic ID

Drug Name: Expedited/Urgent

Directions:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign: Q1. Is this request for initial or continuing therapy? Q2. Please indicate the patient's diagnosis for the requested medication: Q3. If the patient's diagnosis is OTHER, please specify: Q4. Please indicate the patient's age: Q5. Are cultures of the airways positive for P. aeruginosa? Q6. For CONTINUING THERAPY in patients younger than 6 years of age, is there a clinical reason to continue therapy, such as symptomatic improvement? Q7. For CONTINUING THERAPY in patients greater than 6 years of age, please select all that apply: Q8. IF THE REQUEST IS FOR OFF-LABEL USE you must provide a unique peer-reviewed journal article to support the request.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Celebrex-1 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is request for initial or continuing therapy?

Initial

Continuing (Start date MM/YY):

Q2. Please indicate the diagnosis for which Celebrex is being requested

Osteoarthritis

Ankylosing spondylitis

Rheumatoid arthritis

Acute Pain

Dysmenorrhea

Juvenile Rheumatoid Arthritis (JRA) in patients 2 years and older

Post-operative pain following CABG surgery

Other

Q3. If the patient's diagnosis is OTHER, please specify:

Q4. Prescriber may provide any additional rationale or details why this member requires a quantity above the plan limit (such as chart notes, lab values, adverse outcomes, treatment failures, or any other additional clinical information to support 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Cerezyme- 3 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is the drug being requested initial therapy or continuing therapy?

Initial

Continuing (Start date MM/YY):

Q2. Please indicate the diagnosis for which Cerezyme is being requested

Type 1 Gaucher's disease

Other

Q3. If the patient's diagnosis is OTHER, please specify:

Q4. Has the diagnosis confirmed by bone marrow histology, DNA testing, or b-glucocerebrosidase enzyme assay (enzyme activity less than 30 percent)?

Yes No

Q5. Does the patient have any of the following?

Anemia

Bone disease

Thrombocytopenia

Hepatomegaly

Splenomegaly

None of the above

Q6. Will the patient be on concurrent therapy with Zavesca?

Yes No

Q7. Continuation of Therapy: For patients that have received at least 24 months of Cerezyme therapy: has the patient had a decrease in liver and spleen volume and/or increase in platelet count and/or increase in Hgb concentration?

Yes No

Q8. Prescriber may provide any additional rationale or details why this member requires a quantity above the plan limit



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Cerezyme- 3 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

(such as chart notes, lab values, adverse outcomes, treatment failures, or any other additional clinical information to support this request):

Q9. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Cimzia-2 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is the request for initial or continuation therapy?

Initial

Continuing (Start date MM/YY):

Q2. Is the patient 18 years of age or older?

Yes No

Q3. Please indicate the diagnosis for which Cimzia is being requested:

Ankylosing spondylitis

Crohn's disease

Psoriatic arthritis

Rheumatoid Arthritis

Other

Q4. If the patient's diagnosis is OTHER, please specify:

Q5. FOR RHEUMATOID ARTHRITIS: Has the patient tried and failed either Enbrel or Humira?

Yes No

Q6. FOR RHEUMATOID ARTHRITIS: please check all that apply:

The patient has had inadequate response to methotrexate (MTX)

The patient has had an inadequate response to another nonbiologic DMARD (e.g., leflunomide, hydroxychloroquine, sulfasalazine) AND MTX is contraindicated or patient is intolerant

The patient has had an intolerance or contraindication to at least 2 nonbiologic DMARDs

None of the above

Q7. FOR CROHN'S DISEASE: Has the patient had an inadequate response or contraindication/intolerance to at least one oral corticosteroid?

Yes No



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Cimzia-2 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Q8. FOR CROHN'S DISEASE: Has the patient had an inadequate response or contraindication/intolerance to Humira?

Yes No

Q9. Has the patient been screened for latent TB infection (LTBI) and assessed for Hepatitis B risk?

Yes No

Q10. For positive latent TB: Has the patient completed treatment or is currently receiving treatment for LTBI?

Yes No

Q11. Will the patient be on concurrent therapy with other biologics?

Yes No

Q12. Does the patient have an active infection (including TB)?

Yes No

Q13. For CONTINUING THERAPY: Has the patient's condition improved or stabilized with current therapy?

Yes No

Q14. Prescriber may provide any additional rationale or details why this member requires a quantity above the plan limit (such as chart notes, lab values, adverse outcomes, treatment failures, or any other additional clinical information to support this request):

Q15. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Dronabinol- 1 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this initial or continuing therapy?

Initial

Continuing (Start date MM/YY):

Q2. Please indicate the patient's diagnosis:

Anorexia associated with AIDS

Nausea and vomiting associated with cancer chemotherapy

Other

Q3. If diagnosis is other, please specify:

Q4. FOR ANOREXIA: Has the patient has had an involuntary weight loss of greater than 10% of pre-illness baseline body weight or a body mass index (BMI) less than 20kg/m2 in the absence of a concurrent illness or medical condition other than HIV that may cause weight loss?

Yes No

Q5. FOR ANOREXIA: Has the patient has failed to respond to a 30-day drug regimen of megestrol (Megace)?

Yes No

Q6. IF CONTINUING THERAPY: Has the patient shown a positive response to therapy by maintaining or increasing their initial weight and/or muscle mass?

Yes No

Q7. FOR N/V: Is the patient currently receiving a chemotherapy or radiation regimen?

Yes No

Q8. FOR N/V: Is oral drug being used as a full therapeutic replacement for an intravenous anti-emetic drug as part of a cancer chemotherapeutic regimen administered within 48 hours of chemo?

Yes No

Q9. FOR N/V: Has the patient had a full trial and failure through at least one cycle of chemotherapy with IV ondansetron?



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Dronabinol- 1 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Yes No

Q10. FOR N/V: Has the patient failed at least one of the following oral anti-emetic agents: metoclopramide, promethazine, prochlorperazine, meclizine, trimethobenzamide, oral 5-HT3 receptor antagonists ?

Yes No

Q11. IF CONTINUING THERAPY: Has the patient shown a positive response to therapy by reduced incidence of emesis and/or nausea?

Yes No

Q12. Please provide any supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other additional clinical information to support a step therapy exception)

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Elaprase- 1 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial

Continuing (Start date MM/YY):

Q2. Please indicate the diagnosis for which Elaprase is being requested

Replacement therapy in mucopolysaccharidosis II (MPS II, Hunter syndrome) for improvement of walking capacity

Other

Q3. If the patient's diagnosis is OTHER, please specify:

Q4. Has the diagnosis of mucopolysaccharidosis II (MPS II, Hunter syndrome) been confirmed by one of the following?

DNA testing

Enzymatic analysis (deficiency of iduronate 2-sulfatase enzyme activity).

None

Q5. Prescriber may provide any supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other additional clinical information) to support an authorization request.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Enbrel-2 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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: Member Number: Date of Birth: Group Number: Address: City, State, Zip: Member Phone: Prescriber Name: Fax: Office Contact: NPI: Address: City, State, Zip: Phone: State Lic ID:

Drug Name: Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial

Continuing (Start date MM/YY):

Q2. Please indicate the patient's diagnosis below:

Crohn's Disease

Juvenile idiopathic arthritis

Plaque psoriasis

Psoriatic arthritis

Rheumatoid arthritis

Other

Q3. If the patient's diagnosis is OTHER, please specify:

Q4. Is the patient 18 years of age or older?

Yes No

Q5. Has the patient been screened for latent TB infection and assessed for Hepatitis B risk?

Yes No

Q6. FOR POSTIVE LATENT TB: Has the patient completed treatment or is currently receiving treatment for LTBI?

Yes No

Q7. FOR HEPATITIS B: Has HBV infection been ruled out or treatment initiated for positive infection?

Yes No

Q8. FOR RHEUMATOID ARTHRITIS: Please check all that apply:

The patient has had inadequate response to methotrexate (MTX)

The patient has had an inadequate response to another nonbiologic DMARD (e.g., leflunomide, hydroxychloroquine,sulfasalazine) AND MTX is contraindicated or patient is intolerant



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Enbrel-2 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

The patient has had an intolerance or contraindication to at least 2 nonbiologic DMARDs
Patient has severely active RA and Enbrel is being used first-line with MTX
None of the above

Q9. FOR POLYARTICULAR JIA: Please check all that apply:

Patient has had an inadequate response to at least one nonbiologic DMARD
Patient has had an intolerance/contraindication to at least 2 nonbiologic DMARDs
None of the above

Q10. FOR PSORIATIC ARTHRITIS: Please check all that apply :

Patient has predominantly peripheral symptoms
Has had an inadequate response to at least an 8-week maximum tolerated dose trial of at least 1 nonbiologic DMARD
DMARD therapy is contraindicated for this patient
None of the above

Q11. FOR PLAQUE PSORIASIS: Please check all that apply:

Greater than 5% BSA affected
Crucial body areas (e.g., feet, hands, face, or genitals) affected
Patient has had an inadequate response to at least a 60-day trial of 2 conventional therapies (e.g., phototherapy, calcipotriene, MTX, acitretin)
Conventional therapies are contraindicated for this patient
None of the above

Q12. FOR CROHN'S DISEASE: Please check all that apply:

Patient has had an inadequate response, a contraindication, or intolerance to at least a 60-day trial of 2 conventional therapies (e.g., sulfasalazine, mesalamine, azathioprine, corticosteroids)
Patient has had an inadequate response or intolerance to either Remicade or Cimzia
None of the above

Q13. Does the patient have any of the following (Check all that apply):

Concomitant use with another biologic medication
Active infection (including TB)
None of the above

Q14. FOR CONTINUATION THERAPY: Has the patient's condition improved or stabilized with Enbrel therapy?

Yes No

Q15. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:
Erwinaze-1

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial therapy

Continuing therapy (Start date MM/YY):

Q2. Please indicate the diagnosis for which Erwinaze is being prescribed:

Acute lymphoblastic leukemia

Other

Q3. If the diagnosis is OTHER, please specify:

Q4. Has the patient developed hypersensitivity to Escherichia coli-derived asparaginase?

Yes

No

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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Erythropoietin-1 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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: Member Number: Date of Birth: Group Number: Address: City, State, Zip: Member Phone: Prescriber Name: Fax: Office Contact: NPI: Address: City, State, Zip: Phone: State Lic ID:

Drug Name: Expedited/Urgent

Directions:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign: (* Mandatory Questions) Q1. Is this request for initial therapy or continuing therapy? Q2. What is the diagnosis? Q3. What is Hemoglobin level? Q4. Is the patient receiving iron supplementation? Q5. Does this patient have uncontrolled hypertension? Q6. Please list all other medications the patient has previously tried for the indicated diagnosis along with the dates and outcomes (e.g. ineffective, adverse reaction, etc). Q7. IF THE REQUEST IS FOR OFF-LABEL USE you must provide a unique peer-reviewed journal article to support therequest. Please attach any medical information that may support approval.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

ESA-1 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign>(* Mandatory Questions)

Q1. Is this request for initial therapy or continuing therapy? *

Initial therapy Continuing therapy

Q2. What is the diagnosis? *

Anemia associated with Chronic Kidney disease or zidovudine (retrovir, azt) use
Anemia associated with myelosuppressive chemotherapy
Prior to surgery anemia
Unknown

Q3. Does the patient have clinical symptoms of anemia?

Yes No

Q4. What is Hemoglobin level?

Hgb less than or = 10g/dl
Hgb between 10g/dl and 11g/dl
Hgb between 11g/dl and 12 g/dl
Hgb greater than 12g/dl

Q5. Does the patient have adequate iron stores?

Yes No

Q6. Is the patient receiving iron supplementation?

Yes No or Unknown

Q7. Does this patient have uncontrolled hypertension?

Yes No Unknown

Q8. Has the patient been instructed by the prescriber to report any signs or symptoms of adverse cardiovascular events or thrombotic events?

Yes No



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

ESA-1 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Q9. For CONTINUING THERAPY after 12 weeks, has the hemoglobin level increased by at least 1g/dl?

Yes No

Q10. For CONTINUING THERAPY after 12 weeks, if the Hgb level is greater than 12g/dl, is the prescriber decreasing the dose?

Yes No

Q11. Please list all other medications the patient has previously tried for the indicated diagnosis along with the dates and outcomes (e.g. ineffective, adverse reaction, etc).

Q12. IF THE REQUEST IS FOR OFF-LABEL USE you must provide a unique peer-reviewed journal article to support therequest. Please attach any medical information that may support approval.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Esbriet-1

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial therapy

Continuing therapy (Start date MM/YY):

Q2. Please indicate the patient's diagnosis for the requested medication:

Idiopathic pulmonary fibrosis (IPF)

Other

Q3. If the patient's diagnosis is OTHER, please specify:

Q4. Is the prescriber a pulmonologist?

Yes No

Q5. Will the patient's hepatic function and liver function tests (LFTs) be monitored?

Yes No

Q6. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Exjade-3 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is the request for initial or continuing therapy?

Initial

Continuing (Start date MM/YY):

Q2. Please indicate the diagnosis for which Exjade is being requested:

Chronic iron overload due to blood transfusions (transfusional hemosiderosis)

Non transfusion-dependent thalassemia syndromes

Other

Q3. If the patient's diagnosis is OTHER, please specify:

Q4. Please indicate the patient's age.

Q5. Is the prescriber a Hematologist?

Yes No

Q6. Does the patient have any of the following?

Advanced malignancy

Creatinine clearance <40 mL/min or evidence of overt proteinuria

High-risk myelodysplastic syndrome (MDS) with poor performance status

Platelet count less than 50 x 10(9)/L

None of the above

Q7. Will the patient have baseline and monthly monitoring of serum ferritin, serum creatinine, creatinine clearance, serum transaminases, and bilirubin?

Yes No

Q8. Is the patient currently using any deferoxamine or iron-containing products?

Yes No



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Exjade-3 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Q9. For patients already receiving Exjade, will the prescriber consider temporary interruption of Exjade when serum ferritin is less than 500 mcg/L?

Yes No

Q10. Please provide any supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other additional clinical information to support an authorization request)

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Fabrazyme-1

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is request for initial or continuing therapy?

Initial

Continuing (Start date MM/YY):

Q2. Please indicate the diagnosis for which the requested medication is being prescribed:

Fabry's disease

Other (Please specify):

Q3. If the patient's diagnosis is OTHER, please specify:

Q4. Has the diagnosis of Fabry disease been confirmed by an enzyme assay showing deficiency of alpha-galactosidase enzyme activity or DNA testing?

Yes No

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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:
Farydak-2

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial therapy

Continuing therapy (Start date MM/YY):

Q2. Please indicate the patient's diagnosis for the requested medication:

Multiple myeloma Other

Q3. If the patient's diagnosis is OTHER, please specify:

Q4. Has the patient received at least 2 prior regimens, including bortezomib (Velcade) and an immunomodulatory agent (e.g. thalidomide, lenalidomide, pomalidomide)?

Yes No

Q5. If the patient has NOT tried any of the medications listed in the previous question, is there a reason these medications cannot be used (i.e. contraindication, history of adverse event, etc)?

Yes (please explain):

No

Q6. Will Farydak be used in combination with bortezomib (Velcade) and dexamethasone?

Yes No

Q7. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Fentanyl Oral-2 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial

Continuing (Start date MM/YY):

Q2. Please indicate the diagnosis for which the requested medication is being prescribed:

Management of breakthrough cancer pain in opioid-tolerant patient

Other

Q3. If the patient's diagnosis is OTHER, please specify:

Q4. Please indicate the patient's age:

Less than 16 years of age

16 to less than 18 years of age

18 years of age or older

Q5. If the patient is currently taking a strong or moderate cytochrome P450 3A4 inhibitor(s) will dosing be monitored and adjustments made if necessary?

Yes

No

Not applicable

Q6. Prescriber may provide any supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other additional clinical information) to support an authorization request.

Q7. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Fulyzaq-1

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial therapy

Continuing therapy (Start date MM/YY):

Q2. Please indicate the patient's diagnosis for the requested medication (select all that apply):

Non-infectious Diarrhea

HIV/AIDS

Other

Q3. If the patient's diagnosis is OTHER, please specify:

Q4. Is the patient currently on antiretroviral therapy?

Yes No

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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Gilotrif-1

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial Therapy

Continuing Therapy (Start date MM/YY):

Q2. Please indicate the patient's diagnosis for the requested medication:

Non-small cell lung cancer

Other

Q3. If the diagnosis is OTHER, please specify:

Q4. Does the member have metastatic non-small cell lung cancer whose tumors have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations as detected by a Food and Drug Administration-approved test?

Yes

No

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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Growth Hormone- 1 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuation therapy?

Initial

Continuing (Start date MM/YY):

Q2. Is the prescriber an: Endocrinologist, Pediatric Nephrologist, Gastroenterologist, Nutritional Support Specialist, or Infectious Disease Specialist?

Yes No

Q3. FOR PEDIATRIC PATIENTS: Please indicate the diagnosis for which growth hormone is being requested

Growth hormone deficiency (GHD)

Short stature associated with Turner syndrome

Prader-Willi syndrome

Growth failure associated with chronic renal insufficiency (CRI)

Growth failure in child born small for gestational age (SGA)

Idiopathic short stature (ISS)

Short stature associated with Noonan syndrome

Short stature or growth failure associated with short stature homeobox gene (SHOX) deficiency

Other (Please Specify):

Q4. FOR ADULT PATIENTS: Please indicate the diagnosis for which growth hormone is being requested:

HIV patients with wasting or cachexia

Adult growth hormone deficiency

Other (Please Specify):

Q5. FOR PEDIATRIC PATIENTS: Does the patient have short stature or slow growth velocity?

Yes No

Q6. FOR PEDIATRIC PATIENTS: Is the patient's bone age delayed?

Yes No



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Growth Hormone- 1 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Q7. FOR PEDIATRIC PATIENTS: Does the patient have pituitary disease?

Yes No

Q8. FOR PEDIATRIC PATIENTS: Has the patient failed 2 stimulation tests?

Yes No

Q9. FOR PEDIATRIC PATIENTS WITH TS or SHOX: Has the diagnosis been confirmed by genetic testing?

Yes No

Q10. FOR PEDIATRIC PATIENTS WITH CRI: Have metabolic, endocrine and nutritional abnormalities been treated or stabilized?

Yes No

Q11. FOR PEDIATRIC PATIENTS WITH CRI: Has the patient had a kidney transplant?

Yes No

Q12. FOR PEDIATRIC PATIENT WITH GHD DUE TO PITUITARY/CNS DISORDER: Does the patient have a low IGF-1/IGFBP3?

Yes No

Q13. FOR PEDIATRIC PATIENTS WITH ISS: Has pediatric GHD has been ruled out with one stimulation test?

Yes No

Q14. FOR ADULT PATIENTS WITHOUT PITUITARY DISEASE: Has the patient failed 2 stimulation tests?

Yes No

Q15. FOR ADULT PATIENTS: Does the patient have at least 3 pituitary hormone deficiencies or panhypopituitarism AND a low IGF-1?

Yes No

Q16. FOR ADULT PATIENTS: Does the patient have LESS than 3 pituitary hormone deficiencies?

Yes No

Q17. FOR ADULT PATIENTS: Has the patient failed one stimulation test?

Yes No

Q18. FOR CONTINUATION THERAPY PEDIATRIC PATIENTS: Has the patient grown more than 2 cm per year and IGF-1 being monitored?

Yes No

Q19. If the patient's diagnosis is OTHER, please specify:

Q20. Please provide any supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other additional clinical information to support a step therapy exception)

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Growthhormone-4 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial

Continuing (Start date MM/YY):

Q2. Is the patient male or female?

Male

Female

Q3. Please indicate the diagnosis for which the requested medication is being prescribed:

Cryptorchidism

Hypogonadotropic hypogonadism

Ovulation induction

Assisted reproductive technology

Other

Q4. If the patient's diagnosis is OTHER, please specify:

Q5. Prescriber may provide any supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other additional clinical information) to support an authorization request.

Q6. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Harvoni-1 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign: (* Mandatory Questions)

Q1. Is this request for initial or continuing therapy?

Initial therapy

Continuing therapy (Start date MM/YY):

Q2. Please indicate the patient's diagnosis below: *

Chronic hepatitis C

Other (please specify):

Q3. What is the total length of therapy being requested (e.g. 8 weeks, 12 weeks, 24 weeks)?

Q4. Is the patient 18 years of age or older?

Yes No

Q5. Please indicate the prescriber's specialty below:

Gastroenterologist

Hepatologist

Infectious disease

Other (please specify):

Q6. What is the patient's HCV genotype/subtype?

Q7. What is the patient's most recent HCV RNA level?

Q8. Is the patient treatment naïve?

Yes No

Q9. If the patient is NOT treatment naïve, please provide all prior regimens the patient has tried and the outcome (i.e. non-response, relapse, intolerance, etc.):



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Harvoni-1 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Q10. Does the patient have cirrhosis?

Yes No

Q11. Will the patient also be taking Amiodarone?

Yes No

Q12. REQUIRED: Must submit clinical documentation of the following:

HCV genotype/subtype (confirmed by HCV RNA level within the last 6 months)

Laboratory results within 6 weeks of initiating therapy (CBC with platelets, AST/ALT, total bilirubin, serum albumin, PT/INR, serum creatinine, GFR)

Q13. Does the patient have cirrhosis?

Yes No

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Care N Care Hepsera Prior Authorization

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is the request for initial or continuing therapy?

Initial therapy

Continuing therapy (Start date MM/YY)

Q2. What is the patient's diagnosis for the requested medication:

Hepatitis B (chronic)

Hepatitis B prophylaxis with liver transplant

Other

Q3. If the diagnosis is OTHER, please specify:

Q4. Is the patient 12 years of age or older?

Yes No

Q5. Is the prescriber a Gastroenterologist, infectious disease specialist, or affiliated with an infectious disease or gastroenterology practice, or a primary care physician with experience in treating HBV?

Yes No

Q6. Has the patient had evidence of a positive HBsAG (+ or -) serological marker for greater than 6 months?

Yes No

Q7. Does the patient have liver biopsy showing chronic hepatitis?

Yes No

Q8. Is the Hepatitis B viral load greater than 20,000 IU/mL (100,000 copies per mL)?

Yes No

Q9. Does the patient have HBeAg-negative HBV?

Yes No

Q10. Is the Hepatitis B viral load greater than 2,000 IU per mL (10,000 copies per mL)?

Yes No



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Care N Care Hepsera Prior Authorization

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Q11. Does the patient have elevations in liver aminotransferases (ALT or AST) that are two (2) times greater than normal?

Yes No

Q12. Does the patient have normal liver aminotransferases (ALT or AST) levels with evidence of significant disease found on biopsy?

Yes No

Q13. Is the patient receiving Intron A?

Yes No

Q14. For CONTINUATION THERAPY: Is there documented clinical improvement shown by a drop in viral load or reduction in the patient's liver aminotransferases?

Yes No

Q15. Is Hepsera being used as a first-line therapy in treatment-naïve patients with HBV?

Yes No

Q16. Is the patient currently taking/receiving tenofovir or PMPA?

Yes No

Q17. Does the patient have renal impairment?

Yes No

Q18. Please provide the following: documented evidence (i.e. lab results) of diagnosis, serological markers or liver biopsy, viral load and liver aminotransferases.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

HRM Amitriptyline-Perphenazine PA

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial

Continuing (Start date MM/YY):

Q2. Please indicate the patient's diagnosis below:

Anxiety/Agitation/Depression

Other (please specify:)

Q3. Is the patient greater than or equal to 65 years of age?

Yes No

Q4. Prescriber may provide any additional supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other clinical information to support this request).

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

HRM Analgesics PA

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial Continuing

Q2. Please indicate the diagnosis for which the requested medication is being prescribed:

Tension or muscle contraction headache

Other (please complete question 3):

Q3. If the diagnosis is other, please specify:

Q4. Is the patient greater than or equal to 65 years of age?

Yes No

Q5. Prescriber may provide any additional supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other clinical information to support this request).

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

HRM Anticholinergics Prior Auth

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial

Continuing (Start date MM/YY):

Q2. Please indicate the patient's diagnosis below:

Paskinson's disease

Drug-induced extrapyramidal symptoms (except tardive dyskinesia)

Other (please specify):

Q3. Is the patient greater than or equal to 65 years of age?

Yes No

Q4. Prescriber may provide any additional supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other clinical information to support this request).

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

HRM Antihistamine PA

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial Continuing

Q2. Please indicate the patient's diagnosis below:

Allergies

Other (please specify:)

Q3. Is the patient greater than or equal to 65 years of age?

Yes No

Q4. Prescriber may provide any additional supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other clinical information to support this request).

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

HRM Barbiturates PA

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial Continuing

Q2. Please indicate the diagnosis for which the requested medication is being prescribed:

Seizures

Other (please complete question 3):

Q3. If the diagnosis is other, please specify:

Q4. Is the patient greater than or equal to 65 years of age?

Yes No

Q5. Prescriber may provide any additional supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other clinical information to support this request).

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

HRM Cyproheptadine Prior Authorization

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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: Member Number: Date of Birth: Group Number: Address: City, State, Zip: Member Phone: Prescriber Name: Fax: Office Contact: NPI: Address: City, State, Zip: Phone: State Lic ID:

Drug Name: Expedited/Urgent

Directions:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign: Q1. Is this request for initial or continuing therapy? Q2. Please indicate the patient's diagnosis below: Q3. If Cyproheptadine is being used for loss of appetite/weight gain, does the patient have an underlying chronic condition causing decreased appetite/weight loss (i.e. cancer, HIV)? Q4. Is the patient greater than or equal to 65 years of age? Q5. Prescriber may provide any additional supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other clinical information to support this request).

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

HRM Digoxin PA

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial Continuing

Q2. Please indicate the diagnosis for which the requested medication is being prescribed:

Atrial Fibrillation

Heart Failure

Other (please complete question 3):

Q3. If the diagnosis is other, please specify:

Q4. Is the patient greater than or equal to 65 years of age?

Yes No

Q5. Prescriber may provide any additional supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other clinical information to support this request).

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

HRM Dipyridamole Prior Authorization

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial

Continuing (Start date MM/YY):

Q2. Please indicate the patient's diagnosis below:

Used with warfarin to decrease thrombosis in patients after artificial heart valve replacement

Other (please specify):

Q3. Is the patient greater than or equal to 65 years of age?

Yes No

Q4. Prescriber may provide any additional supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other clinical information to support this request).

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

HRM Disopyramide/Norpace PA

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial Continuing

Q2. Please indicate the patient's diagnosis below:

Ventricular arrhythmia

Other (please specify:)

Q3. Is the patient greater than or equal to 65 years of age?

Yes No

Q4. Prescriber may provide any additional supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other clinical information to support this request).

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

HRM Estrogens Prior Authorization

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial

Continuing (Start date MM/YY):

Q2. Please indicate the patient's diagnosis below:

Menopausal Symptoms

Vulvar/Vaginal atrophy

Prostate Cancer (Palliative Care)

Breast Cancer (Palliative Care)

Other (please specify):

Q3. Is the patient greater than or equal to 65 years of age?

Yes No

Q4. Prescriber may provide any additional supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other clinical information to support this request).

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

HRM GI Medications Prior Authorization

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial therapy

Continuing (Start date MM/YY):

Q2. Please indicate which medication is being requested:

Lomotil (atropine/diphenoxylate)

Bentyl (dicylomine)

Q3. Please indicate the diagnosis for which the requested medication is being prescribed:

Diarrhea

Irritable bowel syndrome

Other (please specify):

Q4. Is the patient greater than or equal to 65 years of age?

Yes No

Q5. Prescriber may provide any additional supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other clinical information to support this request).

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

HRM Guanfacine ER (Intuniv) PA

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial Continuing

Q2. Please indicate the diagnosis for which the requested medication is being prescribed:

ADHD

Other (please complete question 3):

Q3. If the diagnosis is other, please specify:

Q4. Is the patient greater than or equal to 65 years of age?

Yes No

Q5. Prescriber may provide any additional supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other clinical information to support this request).

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

HRM Guanfacine/Tenex/Methyldopa PA

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial

Continuing (Start date MM/YY):

Q2. Please indicate the patient's diagnosis below:

Hypertension

Other (please specify:)

Q3. Is the patient greater than or equal to 65 years of age?

Yes No

Q4. Prescriber may provide any additional supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other clinical information to support this request).

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

HRM Hydroxyzine Prior Authorization

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial therapy

Continuing (Start date MM/YY):

Q2. Please indicate the diagnosis for which the requested medication is being prescribed:

Anxiety

Pruritis

Nausea

Other (please specify):

Q3. Is the patient greater than or equal to 65 years of age?

Yes

No

Q4. Prescriber may provide any additional supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other clinical information to support this request).

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

HRM Indomethacin PA

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial Continuing

Q2. Please indicate the diagnosis for which the requested medication is being prescribed:

Moderate to severe rheumatoid arthritis

Moderate to severe osteoarthritis

Acute gouty arthritis

Other (please complete question 3):

Q3. If the diagnosis is other, please specify:

Q4. Is the patient greater than or equal to 65 years of age?

Yes No

Q5. Prescriber may provide any additional supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other clinical information to support this request).

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

HRM Muscle Relaxant Prior Auth

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is the request for initial or continuing therapy?

Initial

Continuing (Start date MM/YY):

Q2. Please indicate the patient's diagnosis below:

Muscle Spasm Other

Q3. If the patient's diagnosis is OTHER, please specify:

Q4. Is the patient greater than or equal to 65 years of age?

Yes No

Q5. Prescriber may provide any additional supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other clinical information to support this request).

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

HRM Oncology-3 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign: (* Mandatory Questions)

Q1. Is this request for initial or continuing therapy?

Initial Continuing

Q2. Please indicate the diagnosis for which the requested medication is being prescribed: *

- Cachexia associated with AIDS
Loss of appetite/weight gain (please complete question 3)
Breast cancer, palliative treatment of advanced disease
Endometrial carcinoma, palliative treatment of advanced disease
Other (please complete question 4):

Q3. If Megestrol is being used for loss of appetite/weight gain, does the patient have an underlying chronic condition causing decreased appetite/weight loss (i.e. cancer, HIV)? If so, please provide underlying condition:

Q4. If the diagnosis is other, please specify:

Q5. Is the patient greater than or equal to 65 years of age?

Yes No

Q6. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

HRM Promethazine Prior Authorization

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial

Continuing (Start date MM/YY):

Q2. Please indicate the patient's diagnosis below:

Allergic Conditions

Nausea

Motion Sickness

Other (please specify):

Q3. Is the patient greater than or equal to 65 years of age?

Yes

No

Q4. Prescriber may provide any additional supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other clinical information to support this request).

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

HRM Promethazine VC Prior Auth

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial

Continuing (Start date MM/YY):

Q2. Please indicate the patient's diagnosis below:

Upper respiratory symptoms (i.e. nasal congestion)

Other (please specify):

Q3. Are patient's symptoms due to an underlying chronic conditions (i.e. asthma, COPD)

No

Yes (please specify in question 7)

Q4. Is the patient greater than or equal to 65 years of age?

Yes No

Q5. Prescriber may provide any additional supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other clinical information to support this request).

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

HRM Sleep Aids PA

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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: Member Number: Date of Birth: Group Number: Address: City, State, Zip: Member Phone: Prescriber Name: Fax: Office Contact: NPI: Address: City, State, Zip: Phone: State Lic ID:

Drug Name: Expedited/Urgent

Directions:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign: Q1. Is this request for initial or continuing therapy? Q2. Please indicate the diagnosis for which the requested medication is being prescribed: Q3. If the diagnosis is other, please specify: Q4. Is the patient greater than or equal to 65 years of age? Q5. Prescriber may provide any additional supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other clinical information to support this request).

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:
HRM TCA PA

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial Continuing

Q2. Which medication is being requested:

- Amitriptyline
Doxepin
Clomipramine (Anafranil)
Imipramine HCl (Tofranil)
Imipramine Pamoate (Tofranil-PM)
Trimipramine (Surmontil)

Q3. Please provide the patient's diagnosis below:

- Obsessive-Compulsive Disorder
Depression
Anxiety
Enuresis
Other (please complete question 4)

Q4. If diagnosis is other, please specify:

Q5. Is the patient greater than or equal to 65 years of age?

Yes No

Q6. Prescriber may provide any additional supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other clinical information to support this request).

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

HRM Trimethobenzamide (Tigan) Prior Authorization

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial therapy

Continuing (Start date MM/YY):

Q2. Please indicate the diagnosis for which the requested medication is being prescribed:

Nausea

Other (please specify):

Q3. Is the patient greater than or equal to 65 years of age?

Yes No

Q4. Prescriber may provide any additional supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other clinical information to support this request).

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Humira-1 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is the request for initial or continuing therapy?

Initial

Continuation (Start date: mm/yy)

Q2. Please indicate the diagnosis for which the requested medication is being prescribed:

Ankylosing Spondylitis

Crohn's Disease

Hidradenitis suppurativa

Juvenile idiopathic arthritis

Plaque psoriasis

Psoriatic arthritis

Rheumatoid arthritis

Ulcerative Colitis

Other

Q3. If the patient's diagnosis is OTHER, please specify:

Q4. Is the patient 18 years of age or older?

Yes

No

Q5. Has the patient been screened for latent TB infection and if Positive, the patient has completed treatment or is currently receiving treatment for LTB?

Yes

No

Q6. Has the patient been screened for Hepatitis B and has HBV infection been ruled out or treatment initiated for positive infection?

Yes

No

Q7. Does the patient have an active infection (including TB) or will be using the requested medication with another biologic



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Humira-1 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

medication?

Yes No

Q8. FOR RHEUMATOID ARTHRITIS: Please check all that apply:

Has had an inadequate response to methotrexate (MTX)

An inadequate response to another nonbiologic DMARD (e.g. leflunomide, hydroxychloroquine, sulfasalazine) if contraindicated or intolerant to MTX

Has had an intolerance or contraindication to at least 2 nonbiologic DMARDs

Humira being uses as first-line therapy with MTX for severely active RA

None of the above

Q9. FOR POLYARTICULAR JIA: Please check all that apply:

Has had an inadequate response to at least one nonbiologic DMARD

Has had intolerance/contraindication to at least 2 nonbiologic DMARDs.

None of the above

Q10. FOR PLAQUE PSORIASIS: Please check all that apply

Greater than 5% BSA affected

Crucial body areas (e.g., feet, hands, face, or genitals) affected

Has had an inadequate response to at least a 60-day trial of 2 conventional therapies (e.g., phototherapy, calcipotriene, MTX, acitretin)

Conventional therapies are contraindicated for this patient

None of the above

Q11. FOR CROHN'S DISEASE: Please check all that apply:

An inadequate response to at least a 60-day trial of 2 conventional therapies (e.g., sulfasalazine, mesalamine, azathioprine, corticosteroids)

Conventional therapies are contraindicated for this patient

Has had an inadequate response or intolerance to either Remicade or Cimzia

None of the above

Q12. FOR PSORIATIC ARTHRITIS: Has the patient had an inadequate response to at least an 8-week maximum tolerated dose trial of at least 1 nonbiologic DMARD unless contraindicated or intolerant to such therapy?

Yes No

Q13. FOR CONTINUATION THERAPY: Has the patient's condition improved or stabilized?

Yes No

Q14. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

HydrocodoneER-1 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is the request for initial or continuing therapy?

Initial therapy

Continuing therapy (Start date MM/YY):

Q2. What is the patient's diagnosis

Q3. Is the patient 18 years of age or older?

Yes No

Q4. Does the patient have severe pain requiring around the clock long term opioid?

Yes No

Q5. Please indicate which of the following have been ineffective, not tolerated or inadequate for controlling pain (check all that apply):

Hydrocodone IR

Oxycodone IR

Morphine IR

Hydromorphone IR

Methadone

Oxymorphone IR

Fentanyl Patch (Duragesic)

None of the above

Q6. Will all other around-the-clock opioids be discontinued when the requested medication is initiated?

Yes No

Q7. Has a care plan/agreement for opioid therapy been established?

Yes No

Q8. Has the patient been advised of risks and provides informed consent for chronic opioid therapy?



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

HydrocodoneER-1 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Yes No

Q9. Has the patient been assessed for the following (check all of the following that the patient has been assessed for):

Pain severity

Suitability of non-opioids

Physical & emotional functional status

Risk of or current aberrant drug behavior

None of the above

Q10. Will the prescriber monitor for signs of misuse, abuse and addiction during therapy?

Yes No

Q11. Is the patient opioid naive/non-tolerant?

Yes No

Q12. Please indicate the starting dose for Zohydro:

Q13. Is the prescriber is knowledgeable in the use of potent opioids for the management of chronic pain?

Yes No

Q14. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Ibrance-1

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial therapy

Continuing therapy (Start date MM/YY):

Q2. Please indicate the patient's diagnosis for the requested medication:

Breast cancer, advanced

Other

Q3. If the diagnosis is OTHER, please specify:

Q4. Will Ibrance be used in conjunction with letrozole (Femara)?

Yes No

Q5. Is the patient a post-menopausal female?

Yes No

Q6. Is the patient's disease estrogen receptor (ER)-positive, human epidermal growth factor receptor 2 (HER2)-negative?

Yes No

Q7. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Iclusig-2

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial therapy

Continuing therapy (Start date MM/YY):

Q2. Please indicate the patient's diagnosis for the requested medication:

Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ALL)

Chronic myeloid leukemia (CML) - accelerated or blast phase

Other (please specify):

Q3. Is the patient T315I positive?

Yes No

Q4. Has the patient tried and failed any of the following tyrosine kinase inhibitors (please select all that apply)?

Bosulif

Gleevec

Imbruvica

Sprycel

Tasigna

None of the above

Q5. If the patient has NOT tried any of the medications listed in the previous question, is there a reason these medications cannot be used (i.e. contraindication, history of adverse event, etc)?

Yes (please explain):

No

Q6. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Imbruvica-1

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial therapy

Continuing therapy (Start date: MM/YY)

Q2. Please indicate the patient's diagnosis for the requested medication:

Chronic lymphocytic leukemia (CLL)

Mantle cell lymphoma (MCL)

Waldenstrom macroglobulinemia

Other

Q3. If diagnosis is OTHER, please specify:

Q4. Has the patient received at least one (1) prior therapy?

Yes No

Q5. For CHRONIC LYMPHOCYTIC LEUKEMIA (CLL), does the patient have 17p chromosome deletion?

Yes No

Q6. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Increlex- 3 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign>(* Mandatory Questions)

Q1. Is the request for initial or continuing therapy?

Initial

Continuing (Start date MM/YY):

Q2. Please indicate the diagnosis for which Increlex is being requested: *

Growth failure severe primary insulin-like growth factor-1 deficiency (IGF-1 deficiency; primary IGFD

Growth failure with growth hormone (GH) gene deletions in a patient that has developed neutralizing antibodies to growth hormone

Other

Q3. If the diagnosis is other, please specify:

Q4. Is the patient between 2 and 20 years of age?

Yes No

Q5. Is the prescriber an Endocrinologist?

Yes No

Q6. Prior to starting therapy, is the patient's height greater than 3 standard deviations (SD) below the mean for chronological age and sex?

Yes No

Q7. Is the patient's IGF-1 level greater than or equal to 3 standard deviations below the mean for chronological age and gender?

Yes No

Q8. Does the patient have one stimulation test showing patient has a normal or elevated GH levels?

Yes No

Q9. For continuation of therapy, has the patient grown more than 2.5 cm/year?

Yes No



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Increlex- 3 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Q10. Are the patient's epiphyses closed?

Yes No

Q11. Will Increlex be administered intravenously?

Yes No

Q12. Does the patient have an active malignancy?

Yes No

Q13. Will Increlex be used concurrently with other growth hormone?

Yes No

Q14. Does the patient have secondary causes of IGF-1 deficiency?

Yes No

Q15. Please provide any supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other additional clinical information to support a step therapy exception)

Q16. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Itraconazole-1 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign: (* Mandatory Questions)

Q1. Is the request for initial or continuing therapy?

Initial

Continuing (Start date MM/YY):

Q2. Please indicate the diagnosis for which Itraconazole is being requested: *

Blastomycosis (pulmonary or extrapulmonary)

Histoplasmosis (incl chronic cavitary pulmonary disease or disseminated, non-meningeal histoplasmosis)

Aspergillosis (pulmonary or extra pulmonary)

Onychomycosis of the toenail, with or without finger nail involvement, due to dermatophytes (tinea unguium)

Onychomycosis of the fingernail due to dermatophytes (tinea unguium)

Other

Q3. For diagnosis OTHER, please define:

Q4. For ONYCHOMYCHOSIS, has the diagnosis has been confirmed with a fungal diagnostic test (e.g., KOH preparation, fungal culture, or nail biopsy)?

Yes No

Q5. Does the patient have ventricular dysfunction (e.g., congestive heart failure (CHF) or history of CHF)?

Yes No

Q6. Is the patient is currently taking any drugs metabolized by CYP3A4 (e.g., cisapride, dofetilide, pimozide, quinidine)?

Yes No

Q7. Please list all other medications the patient has previously tried for the indicated diagnosis along with the dates and outcomes (e.g. ineffective, adverse reaction, etc)

Q8. 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.



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Itraconazole-1 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISSION RX OPTIONS 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:

--	--

Physician Signature

Date

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document.



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Ivig- 1 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is the request for initial or continuing therapy?

Initial

Continuing (Start date MM/YY):

Q2. Please indicate the diagnosis for which IVIG therapy is being requested:

Acute and chronic immune Idiopathic Thrombocytopenic Purpura (ITP)

Chronic inflammatory demyelinating polyneuropathy (CIDP)

Primary humoral immunodeficiency syndrome (congenital agammaglobulinemia, severe combined immunodeficiency syndromes [SCIDS], common variable immunodeficiency, X-linked immunodeficiency, Wiskott-Aldrich syndrome)

Prevention of bacterial infection in patients with hypogammaglobulinemia and/or recurrent bacterial infections with B-cell chronic lymphocytic leukemia (CLL)

Prevention of coronary artery aneurysms associated with Kawasaki syndrome

Other

Q3. If the patient's diagnosis is OTHER, please specify:

Q4. For Kawasaki syndrome: Will IGIV be used in conjunction with high-dose aspirin?

Yes

No

Q5. For CIDP: Has diagnosis been confirmed by a neurologist?

Yes

No

Q6. Does the patient have IgA deficiency with antibody formation and a history of hypersensitivity?

Yes

No

Q7. Does the patient have a history of anaphylaxis or severe systemic reaction to human immune globulin?

Yes

No

Q8. Does the patient have any risk factor(s) for acute renal failure, unless the patient will receive IGIV products at the minimum concentration available and at the minimum rate of infusion practicable?



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Ivig- 1 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Yes No

Q9. If IVIG will be administered via subcutaneous route outside of a controlled healthcare setting, will appropriate treatment (eg, anaphylaxis kit) be available for managing an acute hypersensitivity reaction?

Yes No Not applicable

Q10. Prescriber may provide any supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other additional clinical information to support a step therapy exception).

Q11. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Kalydeco-1 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial therapy

Continuing therapy (Start date MM/YY):

Q2. Please indicate which medication this request is for:

Kalydeco oral tablets

Kalydeco oral granules

Q3. Please indicate the patient's diagnosis for the requested medication:

Cystic Fibrosis (CF)

Other (please specify):

Q4. Please indicate the patient's age below:

0-1 year

2-5 years

6 years or older

Q5. Does the patient have one of the following mutations in the cystic fibrosis transmembrane conductance regulator (CFTR) gene: G551D, G1244E, G1349D, G178R, G551S, R117H, S1251N, S1255P, S549N, S549R?

Yes

No

Q6. For CONTINUING THERAPY, has the patient experienced a benefit from therapy (i.e. improvement in pulmonary lung function [FEV1] or decreased number of pulmonary exacerbations)?

Yes

No

Q7. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:
Keytruda-2

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is the request for initial or continuing therapy?

Initial therapy

Continuing therapy (Start date MM/YY):

Q2. Please indicate the patient's diagnosis below:

Metastatic malignant melanoma

Unresectable malignant melanoma

Other

Q3. If OTHER, please specify:

Q4. Is the patient's melanoma BRAF V600 mutation positive?

Yes No

Q5. Please indicate the medication(s) the patient has experienced a trial and failure to therapy.

Yervoy

Tafinlar

Zelboraf

Other (please specify):

None of the above

Q6. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Kineret-2 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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: Member Number: Date of Birth: Group Number: Address: City, State, Zip: Member Phone: Prescriber Name: Fax: Office Contact: NPI: Address: City, State, Zip: Phone: State Lic ID:

Drug Name: Expedited/Urgent

Directions:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign: Q1. Is this request for initial or continuing therapy? Q2. Please indicate the diagnosis for the requested medication below: Q3. If the patient's diagnosis is OTHER, please specify: Q4. Will Kineret be used concurrently with other biologics? Q5. Does the patient have an active infection? Q6. FOR RHEUMATOID ARTHRITIS: Please select any that apply below: Q7. FOR CONTINUATION THERAPY: Has the patient's condition improved or stabilized? Q8. Please provide any supporting clinical statements...



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Kineret-2 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Q9. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Korlym-1 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign>(* Mandatory Questions)

Q1. Is this request for initial or continuing therapy?

Initial therapy

Continuing therapy (Start date MM/YY):

Q2. Please indicate the patient's diagnosis for this medication *

Hyperglycemia Other

Q3. If the patient's diagnosis is OTHER, please specify:

Q4. If the patient is female, is she pregnant?

Yes No Unknown

Q5. Please select all that apply to this patient:

Hyperglycemia is secondary to hypercortisolism

Patient has endogenous Cushing syndrome

Patient has type 2 diabetes mellitus or glucose intolerance

Patient has failed surgery or is not a candidate for surgery

Q6. Please list all other medications the patient has previously tried for the indicated diagnosis along with the dates and outcomes (e.g. ineffective, adverse reaction, etc)

Q7. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Kuvan-2 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign: (* Mandatory Questions)

Q1. Is this request for initial or continuing therapy?

Initial therapy

Continuing Therapy (Start date MM/YY:)

Q2. Please indicate the diagnosis for which the requested medication is being prescribed: *

To reduce blood phenylalanine (Phe) levels in patients with hyperphenylalaninemia (HPA)

Other

Q3. If diagnosis is OTHER, please specify:

Q4. What is the patient's age?

Less than equal to 12 years

Greater than 12 years

Q5. What is the pretreatment blood phenylalanine (Phe) level?

Greater than or equal to 10mg/dl

Between 6mg/dl and 10mg/dl

Less than 6mg/dl

Q6. For CONTINUING THERAPY, is there a documented response to therapy as defined by greater than or equal to 30% reduction in baseline Phe level

Yes No

Q7. Please list all other medications the patient has previously tried for the indicated diagnosis along with the dates and outcomes (e.g. ineffective, adverse reaction, etc)

Q8. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Letairis-2 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is the request for initial or continuing therapy?

Initial

Continuing (Start date MM/YY):

Q2. Please indicate the diagnosis for which Letairis is being requested

Pulmonary artery hypertension (PAH)

Other

Q3. If the patient's diagnosis is OTHER, please specify:

Q4. Does the patient have NYHA class II or III symptoms?

Yes No

Q5. Has PAH been confirmed by right heart catheterization?

Yes No

Q6. For FEMALE patients, is the patient pregnant?

Yes No

Q7. For female patients of childbearing potential, is the patient using a uterine contraceptive device or two appropriate contraceptive methods?

Yes No

Q8. Prescriber may provide any additional rationale or details why this member requires a quantity above the plan limit (such as chart notes, lab values, adverse outcomes, treatment failures, or any other additional clinical information to support this request):

Q9. Is the patient male or female?

Male Female

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Care N Care Leukine Prior Authorization

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Please indicate the diagnosis for which Leukine is being requested:

Acute myelogenous leukemia (AML), following induction chemotherapy

Bone marrow transplant (allogeneic or autologous) failure or engraftment delay

Myeloid reconstitution after allogeneic bone marrow transplantation

Myeloid reconstitution after autologous bone marrow transplantation: Non-Hodgkin's lymphoma (NHL), acute lymphoblastic leukemia (ALL), Hodgkin's lymphoma

Peripheral stem cell transplantation: Mobilization and myeloid reconstitution following autologous peripheral stem cell transplantation

Other, please define below

Q2. For patient's with nonmyeloid malignancies receiving myelosuppressive chemotherapy, please check all that apply:

Leukine is being used for the prevention of chemotherapy-induced febrile neutropenia and the has patient

experienced

febrile neutropenia with a prior chemotherapy cycle

The patient is at high risk (greater than 20%) for developing febrile neutropenia

The patient is at intermediate risk (10-20%) for developing febrile neutropenia.

The patient at low risk (less than 10%) for developing febrile neutropenia and there is a significant risk for serious medical consequences due to febrile neutropenia and the intent of chemotherapy is to prolong survival or cure the disease.

Q3. Is Leukine being requested for treatment of febrile neutropenia in a patient who have received prophylaxis with Leukine?

Yes No

Q4. Will Leukine be administered within 24 hours preceding or following chemotherapy or radiotherapy?

Yes No

Q5. Is Leukine being used for prophylaxis to to increase the chemotherapy dose intensity or dose schedule above established regimens?

Yes No



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Care N Care Leukine Prior Authorization

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Q6. For treatment of febrile neutropenia: Did the patient receive Neulasta during the current chemotherapy cycle?

Yes No

Q7. For AML only, does the patient have excessive (greater than or equal to 10%) leukemic myeloid blasts in the bone marrow or peripheral blood?

Yes No

Q8. If the patient's diagnosis is OTHER, please specify:

Q9. Please provide any supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other additional clinical information to support a step therapy exception)

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

LidocainePatch-2 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial therapy

Continuing therapy (Start date MM/YY):

Q2. Please indicate the patient's diagnosis for the requested medication:

Post-herpetic neuralgia

Diabetic Peripheral Neuropathy

Other

Q3. If the diagnosis is OTHER, please specify:

Q4. Has the patient previously tried and failed or had an intolerance to at least one other medication which is labeled for the treatment of neuropathic pain (e.g. Cymbalta, Lyrica)?

Yes No

Q5. Please list all medications the patient has previously tried and failed for neuropathic pain:

Q6. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Lupron-1 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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: Member Number: Date of Birth: Group Number: Address: City, State, Zip: Member Phone: Prescriber Name: Fax: Office Contact: NPI: Address: City, State, Zip: Phone: State Lic ID:

Drug Name: Expedited/Urgent

Directions:

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

Q1. Please indicate the diagnosis for which this drug is being requested:

- Anemia caused by uterine leiomyomata (fibroids)
Central precocious puberty (CPP)
Endometriosis
Prostate cancer
Other, please define below

Q2. If the diagnosis is OTHJER, please define and provide further information below.

Q3. Is the patient pregnant and/or breast feeding?

Yes No

Q4. FOR ENDOMETRIOSIS: Has the patient tried and failed at least 2 of the following therapies: oral contraceptives, medroxyprogesterone, or danazol?

Yes No

Q5. FOR CPP: Is the patient less than 12 years old if female and less than 13 years old if male?

Yes No

Q6. FOR PROSTATE CANCER: Is leuprolide being used as neoadjuvant androgen deprivation therapy (ADT) for radical prostatectomy?

Yes No

Q7. FOR PROSTATE CANCER: Leuprolide is being requested for:

- Locally advanced, recurrent or metastatic disease
Initial long-term neoadjuvant/concurrent/adjuvant ADT in combination with radiation therapy for clinically localized disease with high risk of recurrence
Initial short-term neoadjuvant/concurrent/adjuvant ADT in combination with radiation therapy for clinically localized disease with intermediate risk of recurrence or with brachytherapy for clinically localized disease with high risk of recurrence



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Lupron-1 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Neoadjuvant therapy in conjunction with brachytherapy in patients with a large prostate to shrink the prostate to an acceptable size for brachytherapy .

None of the above

Q8. Please provide any supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other additional clinical information to support a step therapy exception)

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Lynparza-2 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial therapy

Continuing therapy (Start date MM/YY):

Q2. Please indicate the patient's diagnosis for the requested medication:

Ovarian cancer, advanced

Other

Q3. If the patient's diagnosis is OTHER, please specify:

Q4. Does the patient have deleterious or suspected deleterious germline BRCA mutation as detected by an FDA approved test?

Yes No

Q5. Has the patient been treated with three (3) or more prior lines of chemotherapy?

Yes No

Q6. If the patient has NOT been treated with three (3) or more prior lines of chemotherapy, is there a reason that Lynparza is preferred over these alternatives?

Yes (please explain):

No

Q7. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Care N Care Methylphenidates PA

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial

Continuing (Start date MM/YY):

Q2. Please indicate the patient's diagnosis:

Attention-deficit/hyperactivity disorder (ADHD)

Narcolepsy

Other

Q3. If the patient's diagnosis is OTHER, please specify:

Q4. Is the patient 6 years of age or older?

Yes No

Q5. If request is for narcolepsy, please submit studies.

Q6. Is the patient currently taking or has the patient taken a monoamine oxidase inhibitor (MAOI) within the last 14 days?

Yes No

Q7. Do the benefits of use outweigh the potential risks of serious cardiovascular events?

Yes No

Q8. Prescriber may provide any supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other additional clinical information) to support an authorization request.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:
Mozobil-2

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Please indicate the patient's diagnosis below:

Autologous stem cell transplantation for the treatment of non-Hodgkin's lymphoma or multiple myeloma

Other

Q2. Will Mozobil be used in combination with granulocyte-colony stimulating factor (i.e. filgrastim or pegfilgrastim)?

Yes No

Q3. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

MS-2 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy

Initial therapy

Continuing therapy (Start date MM/YY):

Q2. What is the patient's diagnosis for the requested medication:

Difficulty walking in patient with clinically diagnosed Multiple Sclerosis

Other

Q3. If the patient's diagnosis is OTHER, please specify:

Q4. Has patient demonstrated walking impairment, but with the ability to walk 25 feet (with or without assistance)?

Yes No

Q5. Does patient have moderate to severe renal impairment (CrCL less than or equal to 50 mL/min), or a history of seizures?

Yes No

Q6. If the request is for CONTINUING THERAPY, has the patient experienced an improvement in walking speed or other objective measure of walking ability since beginning therapy with Ampyra?

Yes No

Q7. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Myozyme- 2 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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: Member Number: Date of Birth: Group Number: Address: City, State, Zip: Member Phone: Prescriber Name: Fax: Office Contact: NPI: Address: City, State, Zip: Phone: State Lic ID:

Drug Name: Expedited/Urgent

Directions:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign: Q1. Is the request for initial or continuing therapy? Q2. Please indicate the diagnosis for which Myozyme is being requested Q3. If the patient's diagnosis is OTHER, please specify: Q4. Has the patient's diagnosis been confirmed by one of the following? Q5. Prescriber may provide any additional rationale or details why this member requires a quantity above the plan limit (such as chart notes, lab values, adverse outcomes, treatment failures, or any other additional clinical information to support this request): Q6. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Naglazyme- 2 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign>(* Mandatory Questions)

Q1. Is this request for initial or continuation therapy?

Initial

Continuing (Start date MM/YY):

Q2. Please indicate the diagnosis for which Naglazyme is being requested *

Replacement therapy in mucopolysaccharidosis VI (MPS VI; Maroteaux-Lamy Syndrome) for improvement of walking and stair-climbing capacity

Other

Q3. If the patient's diagnosis is OTHER, please specify:

Q4. Has the diagnosis confirmed by DNA testing or an enzymatic assay showing a deficiency in N-acetylgalactosamine activity?

Yes No

Q5. Does the patient have at least one MPS VI symptom?

Yes No

Q6. FOR CONTINUATION THERAPY: Has the patient had improvement in walking and/or stair-climbing capacity?

Yes No

Q7. Please provide any supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other additional clinical information to support a step therapy exception)

Q8. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Neulasta- 1 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is the request for initial or continuing therapy?

Initial

Continuing (Start date MM/YY):

Q2. Please indicate the patient's diagnosis for the requested medication below:

Prevention of chemotherapy-induced neutropenia (non-myeloid malignancies)

Other

Q3. If the patient's diagnosis is OTHER, please specify:

Q4. For prevention of chemotherapy-induced febrile neutropenia please answer the following (select all that apply):

Patient experienced febrile neutropenia with a prior chemotherapy cycle

The patient is at high risk (greater than 20%) or intermediate risk (10-20%) for developing febrile neutropenia

Patient is at low risk (less than 10%) but is at significant risk for serious medical consequences due to febrile neutropenia and the intent of chemotherapy is to prolong survival or cure the disease

Q5. Are the patient's complete blood count and platelet count being monitored at baseline, and a regularly thereafter?

Yes No

Q6. Please indicate if the patient has any of the following (select all that apply):

Treatment of febrile neutropenia

Known hypersensitivity to filgrastim

Use in the period 14 days before and 24 hours after administration of chemotherapy

Use in patients with myeloid malignancy

Use to increase the chemotherapy dose intensity or dose schedule beyond established regimens

Q7. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Neupogen-2 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign>(* Mandatory Questions)

Q1. Is the request for initial or continuing therapy?

Initial

Continuing (Start date MM/YY):

Q2. Please indicate the patient's diagnosis below: *

Acute myeloid leukemia patients following induction or consolidation chemotherapy

Bone marrow transplantation

Myelosuppressive chemotherapy recipients with nonmyeloid malignancies

Peripheral blood progenitor cell collection and therapy

Severe chronic neutropenia

Other

Q3. If the patient's diagnosis is OTHER, please specify:

Q4. For prevention of chemotherapy-induced febrile neutropenia please answer the following (select all that apply):

Patient experienced febrile neutropenia with a prior chemotherapy cycle

The patient is at high risk (greater than 20%) or intermediate risk (10-20%) for developing febrile neutropenia

Patient is at low risk (less than 10%) but is at significant risk for serious medical consequences due to febrile neutropenia and the intent of chemotherapy is to prolong survival or cure the disease

Q5. Are the patient's complete blood count and platelet count being monitored at baseline, and regularly thereafter?

Yes

No

Q6. Please indicate if any of the following apply to this patient (select all that apply):

Treatment of febrile neutropenia, when patient receives Neulasta during the current chemotherapy cycle

E. coli hypersensitivity

Administration within 24 hours preceding or following chemotherapy or radiotherapy

Use in patients with myeloid malignancy



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Neupogen-2 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Use to increase the chemotherapy dose intensity or dose schedule beyond established regimens

Q7. 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.

Q8. Please list all other medications the patient has previously tried for the indicated diagnosis along with the dates and outcomes (e.g. ineffective, adverse reaction, etc)

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:
Northera-2

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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.

Form with two columns: Patient Name (Member Number, Date of Birth, Group Number, Address, City, State, Zip, Member Phone) and Prescriber Name (Fax, Phone, Office Contact, NPI, State Lic ID, Address, City, State, Zip).

Drug Name: Expedited/Urgent

Directions:

Large form box containing questions Q1 through Q6 regarding medical history, diagnosis, symptoms, and off-label use.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Nuedexta- 1 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial

Continuing (Start date MM/YY):

Q2. Please indicate the diagnosis for which Nuedexta is being requested:

Pseudobulbar affect (PBA)

Other

Q3. If the patient's diagnosis is OTHER, please specify:

Q4. Does the patient also have one of the following diagnosis?

Amyotrophic lateral sclerosis (ALS)

Multiple sclerosis (MS)

None of the above

Q5. Prescriber may provide any additional rationale or details why this member requires a quantity above the plan limit (such as chart notes, lab values, adverse outcomes, treatment failures, or any other additional clinical information to support this request):

Q6. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Nuvigil- 1 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial

Continuing (Start date MM/YY):

Q2. Please indicate the diagnosis for which Nuvigil is being requested:

Narcolepsy

Shift work sleep disorder (SWSD)

Obstructive sleep apnea/hypopnea syndrome (OSAHS)

Other

Q3. If the patient's diagnosis is OTHER, please specify:

Q4. For OSAHS: Does the patient have MILD obstructive sleep apnea/hypopnea syndrome?

Yes No

Q5. FOR OSAHS: Is the patient using and compliant with an oral appliance?

Yes No

Q6. FOR SWSD: Does the patient work the night shift (at least 6 hours between the hours of 10pm and 8am) permanently or work the night shift (at least 6 hours between the hours of 10pm and 8am) frequently (5 times or more per month) AND experience excessive sleepiness while working?

Yes No

Q7. Prescriber may provide any additional supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other clinical information to support this request).

Q8. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Octreotide- 1 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign: (* Mandatory Questions)

Q1. Is this request for initial or continuing therapy?

Initial

Continuing (Start date MM/YY):

Q2. Please indicate the diagnosis for which Sandostatin (octreotide) is being requested: *

Metastatic carcinoid tumors

Watery diarrhea associated with vasoactive intestinal peptide-secreting tumors (VIPomas)

Acromegaly

Other

Q3. If the patient's diagnosis is OTHER, please specify:

Q4. Prescriber may provide any supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other additional clinical information) to support an authorization 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Opdivo-1 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial therapy

Continuing therapy (Start date MM/YY):

Q2. Please indicate the patient's diagnosis for the requested medication:

Melanoma (unresectable or metastatic)

Non-small cell lung cancer (squamous cell, metastatic)

Other (please specify):

Q3. For MELANOMA, is the patient BRAF V600 mutation positive?

Yes No

Q4. For MELANOMA, has the patient tried any of the following (please select all that apply)?

Yervoy (ipilimumab)

BRAF inhibitor (e.g. Tafenlar, Zelboraf)

None of the above

Q5. For MELANOMA, if the patient has NOT tried any of the medications listed in the previous question, is there a reason these medications cannot be used (i.e. contraindication, history of adverse event, etc)?

Yes (please explain):

No

Q6. For NON-SMALL CELL LUNG CANCER, has the patient's disease progressed on or after platinum based chemotherapy?

Yes No

Q7. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Orencia-2 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is the request for initial or continuing therapy?

Initial

Continuing (Start date MM/YY):

Q2. Please indicate the diagnosis for which Orencia is being requested:

Rheumatoid arthritis (RA)

Juvenile idiopathic arthritis (JIA)

Other (Please Specify):

Q3. If the patient's diagnosis is OTHER, please specify:

Q4. For a diagnosis of RA, please check all that apply:

The patient has had inadequate response to methotrexate (MTX)

The patient has had an inadequate response to another nonbiologic DMARD (e.g., leflunomide, hydroxychloroquine, sulfasalazine) and MTX is contraindicated or patient is intolerant.

The patient has had an intolerance or contraindication to at least 2 nonbiologic DMARDs

Orencia is being used as first-line therapy with MTX for severely active RA

None of the above

Q5. For a diagnosis of Polyarticular JIA, has the patient had an inadequate response to at least one nonbiologic DMARD or intolerance/contraindication to at least 2 nonbiologic DMARDs?

Yes No

Q6. Will Orencia be used concurrently with another biologic agent?

Yes No

Q7. Does the patient have an active infection (including TB)?

Yes No

Q8. Has the patient been screened for latent TB infection and assessed for Hepatitis B risk? And if positive the patient has



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Orencia-2 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

completed treatment or is currently receiving treatment for LTBI and/or HBV infection has been ruled out or treatment initiated for positive infection?

Yes No

Q9. For CONTINUATION OF THERAPY: Has the patient's condition improved or stabilized?

Yes No

Q10. Please provide any supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other additional clinical information) to support an authorization.

Q11. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

OsteoporosisGroup- Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign>(* Mandatory Questions)

Q1. Is this request for new therapy or continuing therapy?

New therapy Continuing therapy

Q2. What is the diagnosis for the drug prescribed? *

Treatment of Osteoporosis
Other

Q3. Has the patient experienced a prior fragility fracture?

Yes No Unknown

Q4. Has the patient had an inadequate response to an adequate trial of a bisphosphonate (one year).

Yes No Unknown

Q5. If the patient did not try a bisphosphonate, was there a contraindication or intolerance to the trial?

Yes No Unknown

Q6. Which of the following risk factors does the patient have for fractures (check all that apply)?

- Age
Parental history of fracture
Low body mass index
Current smoker
Chronic alcohol use
Rheumatoid arthritis
Chronic steroid use
Other secondary cause of Osteoporosis

Q7. Please list all other medications the patient has previously tried for the indicated diagnosis along with the dates and outcomes (e.g. ineffective, adverse reaction, etc)

Q8. IF THE REQUEST IS FOR OFF-LABEL USE you must provide a unique peer-reviewed journal article to support the



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

OsteoporosisGroup- Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

request. Please attach any medical information that may support approval.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Oxsoralen- 1 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is the request for initial or continuing therapy?

Initial

Continuing (Start date MM/YY):

Q2. Please indicate the diagnosis for which Oxsoralen is being requested:

Cutaneous T-cell lymphoma

Psoriasis

Other

Q3. If the patient's diagnosis is OTHER, please specify:

Q4. If the diagnosis is psoriasis, has the patient the patient tried and failed, is intolerant of or has a contraindication to at least one topical steroid?

Yes No

Q5. Does the patient have aphakia, melanoma or invasive squamous cell carcinoma?

Yes No

Q6. Is the prescriber a Dermatologist, Oncologist or affiliated with a dermatologist/oncologist practice?

Yes No

Q7. Please provide any supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other additional clinical information) to support an authorization.

Q8. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

PAH-8 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial Therapy

Continuing Therapy (please complete question 2)

Q2. For continuation therapy, please provide date therapy started:

Q3. Please indicate the diagnosis:

Pulmonary arterial hypertension (PAH) (World Health Organization [WHO] group I)

Other (please complete question 4)

Q4. If diagnosis is other, please specify:

Q5. Prescriber may provide any supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other additional clinical information) to support an authorization request.

Q6. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:
Pegasys-2

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign: (* Mandatory Questions)

Q1. Is this request for initial or continuing therapy?

Initial therapy

Continuing therapy (Start date MM/YY):

Q2. Please indicate the patient's diagnosis for the requested medication: *

Chronic Hepatitis B

Chronic Hepatitis C

Other

Q3. If the patient's diagnosis is OTHER, please specify:

Q4. For CHRONIC HEPATITIS C, please indicate the patient's genotype below:

Q5. For CHRONIC HEPATITIS C, is the patient treatment naïve or experienced?

Treatment naïve (i.e. no previous treatment for Hepatitis C)

Treatment experienced (i.e. has received treatment for Hepatitis C in the past)

Q6. For CHRONIC HEPATITIS C, will Pegasys be used in conjunction with Sovaldi?

Yes

No

Q7. For CHRONIC HEPATITIS C, if the patient is treatment-experienced, please list all previous treatment regimens as well as the response to the regimen (i.e. non-responder, relapser, etc):

Q8. For CHRONIC HEPATITIS C, please list all medications the patient will be taking in conjunction with Pegasys:

Q9. For CHRONIC HEPATITIS C, please list the anticipated duration of therapy:

Q10. For CHRONIC HEPATITIS B, please select all that apply to this patient:

Patient has evidence of hepatitis B viral replication

Patient has been serum hepatitis B surface antigen (HBsAG)-positive for at least 6 months



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:
Pegasys-2

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

None of the above

Q11. Does the patient have any of the following (please select all that apply)?

Decompensated liver disease

Autoimmune hepatitis

Concomitant administration of didanosine with ribavirin in patients co-infected with HIV

None of the above

Q12. Please select the prescriber's specialty:

Infectious disease (ID)

Gastroenterology

Oncology

Other (please specify):

Q13. Will the patient be monitored for evidence of depression?

Yes No

Q14. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Pegintron-1

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial therapy

Continuing therapy (Start date MM/YY):

Q2. Please indicate the patient's diagnosis for the requested medication:

Chronic Hepatitis C Other

Q3. If the patient's diagnosis is OTHER, please specify:

Q4. Please provide the patient's genotype below:

Q5. Prior to initiating therapy, does the patient have detectable levels of HCV RNA in the serum?

Yes No

Q6. Will Pegintron be used in conjunction with Sovaldi?

Yes No

Q7. Is the patient treatment naïve or experienced?

Treatment naïve (i.e. has never been treated for hepatitis C)

Treatment experienced (i.e. has received treatment for hepatitis C in the past)

Q8. Does the patient have any of the following (please select all that apply)?

Decompensated liver disease

Autoimmune hepatitis

Concomitant administration of didanosine with ribavirin in patients co-infected with HIV.

None of the above

Q9. Please indicate the prescriber's specialty below:

Infectious disease (ID)



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Pegintron-1

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Gastroenterology

Oncology

Other (please specify):

Q10. Will the patient be monitored for evidence of depression?

Yes No

Q11. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Prolia-2 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial

Continuing (Start date MM/YY):

Q2. Please indicate the patient's diagnosis:

Bone loss due to cancer therapy

Osteoporosis

Other

Q3. If the patient's diagnosis is OTHER, please specify:

Q4. Is the patient hypocalcemic?

Yes No

Q5. If yes, is the patient being supplemented with calcium and Vitamin D?

Yes No

Q6. Prescriber may provide any supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other additional clinical information) to support an authorization.

Q7. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Promacta-3 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is request for initial or continuing therapy?

Initial Continuing

Q2. Please indicate the diagnosis for which the requested medication is being prescribed:

Idiopathic thrombocytopenic purpura (ITP)

Hepatitis C, thrombocytopenia

Other (please specify):

Q3. Has the patient been evaluated for other causes of thrombocytopenia AND has had an insufficient response or intolerance to corticosteroids, immunoglobulins, or splenectomy?

Yes No

Q4. Is the platelet (Plt) count at time of diagnosis: less than 30,000/mcL OR less than or equal to 50,000/mcL with significant mucous membrane bleeding or risk factors for bleeding?

Yes No

Q5. Will liver function be assessed pretreatment and regularly throughout therapy?

Yes No

Q6. Are alanine aminotransferase levels greater than or equal to 3 times the upper limit of normal with any of the following characteristics: progressive, persistent, accompanied by increased bilirubin or symptoms of liver injury or evidence of hepatic decompensation?

Yes No

Q7. For CONTINUING therapy: Has the Plt count responded to Promacta defined as: Platelet count has increased to at least 50,000/mcL?

Yes

No (please proceed to question 8)

Q8. For CONTINUING therapy and patient's platelet count less than 50,000/microliter: Has platelet count increased to a level sufficient to avoid clinically important bleeding after at least 4 weeks of Promacta at a maximal dose?

Yes No



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Promacta-3 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Q9. For CONTINUING therapy: If Plt counts rise above 200,000/mcL with Promacta, will therapy be adjusted to maintain the minimal count needed to reduce the patient's risk for bleeding?

Yes No

Q10. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:
Provigil-2

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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.

Form with two columns: Patient Name and Prescriber Name. Fields include Member Number, Date of Birth, Group Number, Address, City, State, Zip, Member Phone, Fax, Office Contact, NPI, Address, City, State, Zip, Phone, and State Lic ID.

Drug Name: Expedited/Urgent

Directions:

Large form box containing questions Q1 through Q6 regarding medical history, diagnosis, and therapy. Q1 asks about initial or continuing therapy. Q2 asks for diagnosis (Narcolepsy, SWSD, OSAHS, Other). Q3 asks for specification of OTHER diagnosis. Q4 asks about oral appliance for OSAHS. Q5 asks about excessive sleepiness for SWSD. Q6 asks for peer-reviewed journal article for off-label use.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Regranex-1

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is the request for initial or continuing therapy?

Initial

Continuing (Start date MM/YY):

Q2. Please indicate the patient's diagnosis for the requested medication below:

Diabetic Neuropathic Ulcer

Other

Q3. If the patient's diagnosis is OTHER, please specify:

Q4. Will treatment be given in combination with ulcer wound care (eg, debridement, infection control, and/or pressurere relief)?

Yes No

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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Relistor-1

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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.

Form with two columns: Patient Name (Member Number, Date of Birth, Group Number, Address, City, State, Zip, Member Phone) and Prescriber Name (Fax, Phone, Office Contact, NPI, State Lic ID, Address, City, State, Zip).

Drug Name: Expedited/Urgent

Directions:

Large form box containing 7 questions (Q1-Q7) regarding medical history, diagnosis, and therapy for the patient.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Revatio-3 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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: Member Number: Date of Birth: Group Number: Address: City, State, Zip: Member Phone: Prescriber Name: Fax: Office Contact: NPI: Address: City, State, Zip: Phone: State Lic ID:

Drug Name: Expedited/Urgent

Directions:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign: Q1. Is this request for initial or continuing therapy? Q2. For which diagnosis is Revatio being requested? Q3. If the patient's diagnosis is OTHER, please specify: Q4. Has PAH been confirmed by right heart catheterization... Q5. Has the patient had an inadequate response or intolerance to Adcirca? Q6. Is the patient currently on nitrate therapy? Q7. Prescriber may provide any supporting clinical statements... Q8. IF THE REQUEST IS FOR OFF-LABEL USE you must provide a unique peer-reviewed journal article...

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Revlimid-3 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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: Member Number: Date of Birth: Group Number: Address: City, State, Zip: Member Phone: Prescriber Name: Fax: Office Contact: NPI: Address: City, State, Zip: Phone: State Lic ID:

Drug Name: Expedited/Urgent

Directions:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign>(* Mandatory Questions)

Q1. Is the request for initial or continuing therapy?

Initial

Continuing (Start date MM/YY):

Q2. Please indicate the patient's diagnosis below: *

Mantle cell lymphoma

Multiple myeloma

Myelodysplastic syndromes

Other

Q3. If the patient's diagnosis is OTHER, please specify:

Q4. FOR ACTIVE MYELOMA: please check all of the following that apply:

Revlimid is used after at least one prior therapy or as salvage therapy

Revlimid is used with dexamethasone as primary induction therapy or in combination with melphalan and prednisone

in nontransplant candidates

Revlimid is used as maintenance monotherapy following response to either stem cell transplant or primary induction therapy

Other

Q5. Is this being used for low or intermediate-1 risk myelodysplastic syndrome (MDS)? *

Yes No

Q6. What type of MDS does the patient have?

5q deletion non-5q deletion

Q7. For 5q DELETION: If being use for low-intermediate risk MDS, please check all of the following that are applicable:

Transfusion-dependent anemia



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Revlimid-3 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Symptomatic anemia with clinically significant cytopenias
Other

Q8. FOR NON-5Q DELETION: Which of the following applies to the patient: please select all applicable
Failed response to epoetin alfa (Procrit, Epogen)
Failed response to darbepoietin (Aranesp)
Pretreatment serum erythropoietin levels greater than 500 mU/mL and a low probability of response to immunosuppressive therapy
Other

Q9. If the Patient is FEMALE: Is the patient currently pregnant? (Negative pregnancy status must be confirmed by 2 tests)
Yes No

Q10. If the patient is female and of child bearing age, how was pregnancy excluded? (check all that apply)
Two negative serums
Two urine pregnancy tests

Q11. FOR MALE and FEMALE: Have patients of childbearing age been instructed on the importance of proper utilization of appropriate contraceptive methods?
Yes No

Q12. Will the patient be monitored for hematologic toxicity with complete blood counters (CBCs) and signs of symptoms of thromboembolism during the course of treatment? *
Yes No

Q13. Please provide any supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other additional clinical information) to support an authorization request.

Q14. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:
Ribavirin-1

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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.

Form with two columns: Patient Name and Prescriber Name. Fields include Member Number, Date of Birth, Group Number, Address, City, State, Zip, Member Phone, Fax, Office Contact, NPI, Address, City, State, Zip, and State Lic ID.

Drug Name: Expedited/Urgent

Directions:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign>(* Mandatory Questions)

Q1. Is this request for initial or continuing therapy?

Initial therapy

Continuing therapy (Start date MM/YY):

Q2. Please indicate the patient's diagnosis for the requested medication: *

Chronic Hepatitis C Other

Q3. If the patient's diagnosis is OTHER, please specify:

Q4. For CHRONIC HEPATITIS C, please indicate the patient's genotype below:

Q5. Please indicate the prescriber's specialty:

Infectious disease (ID)

Gastroenterology

Oncology

Other (Please specify):

Q6. REQUIRED: Please submit chart notes/written medical summary documenting the diagnosis of chronic hepatitis C as well as recent lab reports documenting elevated HCV RNA and genotype. Have these been submitted with this request (please check off all that have been submitted)?

Chart notes/medical summary documenting diagnosis of chronic hepatitis C

Recent lab reports documenting elevated HCV RNA

Recent lab reports documenting patient's genotype

None of the above have been submitted

Q7. Please select if any of the following apply to this patient:

Hemoglobin less than 8.5 mg/dL

Hemoglobinopathy



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:
Ribavirin-1

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

- History of unstable heart disease
- Creatinine clearance less than 50 mL/minute and unwilling to use modified dose of ribavirin
- Pregnancy (self or partner)
- Unwilling to use effective contraception
- Co-administration with didanosine in HIV co-infected patients
- None of the above

Q8. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Rituxan-3 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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: Member Number: Date of Birth: Group Number: Address: City, State, Zip: Member Phone: Prescriber Name: Fax: Office Contact: NPI: Address: City, State, Zip: Phone: State Lic ID:

Drug Name: Expedited/Urgent

Directions:

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

Q1. Is this initial or continuing therapy?

Initial

Continuing (Start date MM/YY):

Q2. Please indicate the patient's diagnosis below:

Non-Hodgkin lymphoma

Rheumatoid Arthritis

Chronic lymphocytic leukemia

Microscopic polyangiitis

Wegener granulomatosis

Other

Q3. If the patient's diagnosis is OTHER, please specify:

Q4. If the diagnosis is Rheumatoid arthritis, please indicate below which therapies the patient has had an inadequate response to.

Enbrel

Humira

Kineret

Remicade

DMARDs (methotrexate, cyclosporine, Azulfidine/sulfasalazine, Plaquenil/hydroxychloroquine, Arava/leflunomide, Imuran/azathioprine, gold compounds

None

Q5. If the diagnosis is Rheumatoid Arthritis indicate if RA is severely active and frontline Rituxan therapy is warranted?

Yes

No

Q6. For CONTINUING RA therapy: has patient shown improvement in clinical symptoms (may include improvement in



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Rituxan-3 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

tender and swollen joint count, mobility, or stiffness, or delay in progression of disease) from the last treatment course?

Yes No

Q7. If for a Hematologic Malignancy, is the malignancy CD20 positive?

Yes No

Q8. Has the patient been assessed for hepatitis B risk prior to initiation of therapy and, if appropriate, ruled out or initiated treatment for hepatitis B?

Yes No

Q9. Will Rituxan be used in combination with chemotherapy (or other agents) for mantle cell lymphoma, Burkitt's lymphoma, lymphoblastic lymphoma, or AIDS-related B-cell lymphoma?

Yes No

Q10. Does the patient have a history of severe skin or infusion reaction with Rituxan that cannot be appropriately managed, or used in combination with another biologic agent?

Yes No

Q11. Is the patient being monitored for pulmonary toxicity?

Yes No

Q12. For medical necessity reviews, you must provide a unique peer-reviewed journal article to support your request for off-label use. Please attach any medical information that may support approval.

Q13. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Samsca-2 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is the request for initial or continuing therapy?

Initial

Continuing (Start date MM/YY):

Q2. Please indicate the diagnosis for which Samsca is being requested:

Hypervolemic hyponatremia

Euvolemic hyponatremia

Other

Q3. If the patient's diagnosis is OTHER, please specify:

Q4. Does the patient have anuria?

Yes No

Q5. Does the patient require and URGENT increase in serum sodium?

Yes No

Q6. Is the patient able to sense and respond to thirst?

Yes No

Q7. Will Samsca be used in combination with a strong CYP 3A inhibitor (e.g., clarithromycin, ketoconazole)?

Yes No

Q8. Will Samsca be initiated or re-initiated in a hospital setting?

Yes No

Q9. Please provide any supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other additional clinical information to support a step therapy exception)

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Sandostatin- 2 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is the request for initial or continuing therapy?

Initial

Continuing (Start date MM/YY):

Q2. Please indicate the diagnosis for which Sandostatin (octreotide) is being requested:

Metastatic carcinoid tumors

Watery diarrhea associated with vasoactive intestinal peptide-secreting tumors (VIPomas)

Acromegaly

Other

Q3. If the patient's diagnosis is OTHER, please specify:

Q4. Has the patient received initial treatment with Sandostatin Injection (not the Depot form) for at least 2 weeks and treatment with Sandostatin Injection was effective and tolerable?

Yes

No

Q5. Please provide any supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other additional clinical information to support a step therapy exception)

Q6. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Serostim- 1 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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: Member Number: Date of Birth: Group Number: Address: City, State, Zip: Member Phone: Prescriber Name: Fax: Office Contact: NPI: Address: City, State, Zip: Phone: State Lic ID:

Drug Name: Expedited/Urgent

Directions:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign: Q1. Is request for initial or continuation therapy? Q2. Please indicate the diagnosis for which Serostim is being requested: Q3. If the patient's diagnosis is OTHER, please specify: Q4. Is the patient on concurrent antiretroviral therapy? Q5. Have alternative causes of wasting have been ruled out or treated appropriately? Q6. Does the patient have history of an acute critical illness, active malignancy or history or malignancy in past 12 months? Q7. For CONTINUATION THERAPY (treated for 12 or more weeks): has the patient's body mass index has improved or stabilized? Q8. Prescriber may provide any supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other additional clinical information to support a step therapy exception).

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Simponi-2 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is request for initial or continuation therapy?

Initial

Continuing (Start date MM/YY):

Q2. Please indicate the diagnosis for which Simponi is being requested:

Rheumatoid arthritis

Psoriatic arthritis

Ankylosing spondylitis

Other

Q3. If the patient's diagnosis is OTHER, please specify:

Q4. FOR RHEUMATOID ARTHRITIS: Has the patient had an inadequate response to methotrexate (MTX)?

Yes No

Q5. FOR RHEUMATOID ARTHRITIS: Is methotrexate contraindicated in this patient or is the patient intolerant to methotrexate?

Yes No

Q6. FOR RHEUMATOID ARTHRITIS: Has the patient tried and failed a nonbiologic DMARD (e.g., leflunomide, hydroxychloroquine, sulfasalazine)?

Yes No

Q7. FOR RHEUMATOID ARTHRITIS: Does the patient have intolerance or contraindication to at least TWO nonbiologic DMARDs?

Yes No

Q8. FOR RHEUMATOID ARTHRITIS: Does the patient have severely active RA and Simponi is being used first line with methotrexate?

Yes No



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Simponi-2 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Q9. FOR ANKYLOSING SPONDYLITIS: Has the patient had an inadequate response or intolerance/contraindication to at least 2 NSAIDs?

Yes No

Q10. Has the patient been screened for latent TB infection and assessed for Hepatitis B risk? And if positive the patient has completed treatment or is currently receiving treatment for LTBI and/or HBV infection has been ruled out or treatment initiated for positive infection?

Yes No

Q11. Does the patient have active infection (including TB)?

Yes No

Q12. Will Simponi be used as concurrent therapy with other biologics?

Yes No

Q13. FOR CONTINUATION THERAPY: Has the patient's condition improved or stabilized?

Yes No

Q14. Please provide any supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other additional clinical information to support a step therapy exception)

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Somatuline-2 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial therapy

Continuing therapy (Start date MM/YY):

Q2. Please indicate the patient's diagnosis for the requested medication:

Acromegaly

Neuroendocrine tumor, gastroenteropancreatic

Other (please specify):

Q3. For ACROMEGALY, please select which of the following applies to this patient:

Patient has had an inadequate response to surgery and/or radiation

Patient cannot be treated with surgery and/or radiation

Other reason

Q4. For CONTINUING THERAPY, has the patient's IGF-1 level normalized or improved?

Yes

No

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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Somavert-3 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is the request for initial or continuing therapy?

Initial

Continuing (Start date MM/YY):

Q2. Is Somavert being prescribed to treat acromegaly?

Yes No

Q3. Has a diagnosis of acromegaly been confirmed by an elevated IGF-1 level or elevated GH level with a glucose tolerance test?

Yes No

Q4. Has the patient tried and failed at least a 3 month trial of Sandostatin or Somatuline?

Yes No

Q5. Is the prescribing physician an endocrinologist?

Yes No

Q6. Will Somavert be administered intravenously (IV)?

Yes No

Q7. Will Somavert be used together with Sandostatin or Somatuline?

Yes No

Q8. FOR CONTINUING THERAPY: Has there been a reduction in IGF-1 level from baseline?

Yes No

Q9. Prescriber may provide any supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other additional clinical information) to support an authorization request.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Soriatane- 1 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Please indicate the patient's diagnosis below:

Psoriasis

Prevention of non-melanoma skin cancers in high risk individual

Other

Q2. Has the patient been unresponsive to other therapies for the disorder?

Yes No

Q3. Please list all therapies the patient has tried and failed

Q4. Do any of the following apply to this patient? (check all that apply):

Severely impaired liver function

Severely impaired kidney function

Chronic abnormally elevated blood lipid value

Patient is currently taking methotrexate

Patient is currently taking tetracycline

None of the above

Q5. Is the patient male or female?

Male Female

Q6. FOR FEMALES: has pregnancy been excluded (as confirmed by 2 negative urine or serum pregnancy tests with a sensitivity of at least 25 mIU/mL)?

Yes No

Q7. FOR FEMALES: please indicate the forms of birth control that the patient will use during therapy with soriatane.

Q8. FOR FEMALES: has the patient agreed to use her chosen form of contraception for at least 1 month before initiation of Soriatane therapy, during Soriatane therapy, and for at least 3 years after discontinuation of therapy?



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Soriatane- 1 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Yes No

Q9. FOR FEMALES: has the patient been advised that ethanol must not be ingested by female patients during Soriatane treatment and for 2 months following therapy?

Yes No

Q10. FOR FEMALES: has the patient agreed to have a pregnancy test on a monthly basis?

Yes No

Q11. Has the female and/or guardian signed a Patient Agreement/Informed Consent?

Yes No

Q12. Prescriber may provide any additional supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other clinical information to support this request).

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Sovaldi-1 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial therapy

Continuing therapy (Start date MM/YY):

Q2. Please provide the patient's diagnosis for the requested medication:

Chronic Hepatitis C Other

Q3. If diagnosis is OTHER, please specify:

Q4. Is the patient 18 years of age or older?

Yes No

Q5. Please indicate the prescriber's specialty:

Gastroenterology

Hepatology

Infectious Disease

Other (please specify:)

Q6. Please provide the patient's genotype:

Q7. What other medications will the patient be taking CONCURRENTLY with Sovaldi (check all that apply):

Ribavirin

Pegasys/Peg-Intron

Olysio

Other (please specify:)

None (will be used as monotherapy)

Q8. Is the patient treatment naïve?



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Sovaldi-1 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Yes No

Q9. Is the patient ineligible to take interferons because of a contraindication or intolerance?

Yes (please complete Q10)

No

Q10. If the patient is interferon ineligible please provide reason:

Q11. Please provide prior regimens the patient has tried and outcome (i.e. non-response, relapse, intolerance)

Q12. Is the patient awaiting liver transplant?

Yes No

Q13. Does the patient have cirrhosis?

Yes No

Q14. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Stelara-2 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial therapy

Continuing therapy (Start date MM/YY):

Q2. Please indicate the patient's diagnosis for the requested medication:

Plaque Psoriasis

Psoriatic Arthritis

Other (please specify:)

Q3. Is the patient 18 years of age or older?

Yes No

Q4. Has the patient been screened for latent tuberculosis?

Yes No

Q5. If results are positive, has patient completed treatment or is patient currently receiving treatment for latent tuberculosis?

Yes

No

N/A (results were not positive)

Q6. Does the patient have an active infection (including tuberculosis)?

Yes No

Q7. Will Stelara be used concurrently with other biologics?

Yes No

Q8. For PLAQUE PSORIASIS, please select if any of the following apply to this patient (select all that apply):

More than 10% body surface area (BSA) is affected

Crucial body areas (e.g. feet, hands, face) are affected

Patient has had an inadequate response to at least a 60-day trial of 2 conventional therapies (e.g., phototherapy,



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Stelara-2 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

calcipotriene, methotrexate, acitretin) unless contraindicated or intolerant to such therapies

Q9. FOR CONTINUING THERAPY, has the patient's condition improved or stabilized?

Yes No

Q10. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:
Stivarga-2

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is the request for initial or continuing therapy?

Initial

Continuing (Start date MM/YY):

Q2. Please indicate the patient's diagnosis below:

GI Stromal Tumors (locally advanced, unresectable or metastatic)

Metastatic Colorectal Cancer

Other

Q3. If the diagnosis is OTHER, please specify:

Q4. For GI STROMAL TUMORS, please select which of the following the patient has previously tried (please select all that apply):

Imatinib (Gleevec)

Sunitinib (Sutent)

Other (Please Specify):

Q5. For METASTATIC COLORECTAL CANCER, please indicate which of the following the patient has previously tried (please select all that apply):

Fluoropyrimidine, oxaliplatin, and irinotecan-based chemotherapy

Bevacizumab (Avastin)

Panitumumab (Vectibix)

Cetuximab (Erbix) (for KRAS mutation-negative patients only)

Other (Please Specify):

Q6. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Strattera- 1 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial

Continuing (Start date MM/YY):

Q2. Please indicate the diagnosis for which Strattera is being requested:

Attention deficit/hyperactivity disorder (ADHD)

Other

Q3. If the patient's diagnosis is OTHER, please specify:

Q4. Is the patient 6 years of age or older?

Yes

No

Q5. Will Strattera be used concurrently with an MAOI or has the patient used an MAOI within the last 14 days?

Yes

No

Q6. Will the patient be monitored for suicidality, clinical worsening, changes in behavior, blood pressure changes, heart rate changes, liver injury?

Yes

No

Q7. Prescriber may provide any supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other additional clinical information) to support an authorization request.

Q8. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Symlin- 2 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial

Continuing (Start date MM/YY):

Q2. Please indicate the patient's diagnosis below:

Diabetes mellitus type 1, adjunctive treatment

Diabetes mellitus type 2, adjunctive treatment

Other

Q3. FOR INITIAL THERAPY: Does the patient have inadequate glycemic control (HbA1c greater than 7% but less than 9%) at initiation of therapy AND currently receiving optimal mealtime insulin therapy?

Yes No

Q4. FOR CONTINUING THERAPY: If the patient has taken Symlin in previous 6 months, have they demonstrated a reduction in HbA1c since initiating Symlin therapy?

Yes No

Q5. Does the patient have any of the following contraindications: Severe hypoglycemia that required assistance during the past 6 months, gastroparesis, or hypoglycemia unawareness?

Yes No

Q6. Prescriber may provide any supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other additional clinical information to support an authorization request).

Q7. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Testosterone-1 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial therapy

Continuing therapy (Start date MM/YY):

Q2. Please indicate the patient's diagnosis below:

Hypogonadism

Deficiency or absence of endogenous testosterone

Other

Q3. If the patient's diagnosis is OTHER, please specify:

Q4. Do any of the following apply to this patient (please select all that apply)?

Patient is female

Patient has prostate cancer

Patient has breast cancer

None of the above

Q5. Please indicate the patient's testosterone level PRIOR to start of therapy:

Total testosterone GREATER than 300 ng/dL, free or bioavailable, testosterone GREATER than 5 ng/dL

Total testosterone LESS than 300 ng/dL, free or bioavailable, testosterone LESS than 5 ng/dL

Absence of endogenous testosterone

Q6. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Thalomid-2 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is the request for initial or continuing therapy?

Initial

Continuing (Start date MM/YY):

Q2. Please indicate the patient's diagnosis below:

Acute treatment of the cutaneous manifestations of moderate to severe erythema nodosum leprosum

Prevention and suppression of the cutaneous manifestations of erythema nodosum leprosum recurrence

Multiple Myeloma

Other

Q3. If the diagnosis is OTHER, please specify below:

Q4. For the diagnosis of multiple myeloma, please check all that apply:

Thalomid is used as salvage or palliative therapy.

Thalomid is used for newly diagnosed disease or as primary induction therapy in combination with dexamethasone

or

in combination with melphalan and prednisone in nontransplant candidates.

Thalomid is used as maintenance monotherapy following response to either stem cell transplant or primary induction therapy.

None of the above

Q5. Will the patient be monitored for signs and symptoms of thromboembolism?

Yes No

Q6. For female patients of childbearing potential, has pregnancy been excluded by a negative pregnancy test?

Yes No

Q7. MALE and FEMALE: have patients of child-bearing potential been instructed on the importance of proper utilization of appropriate contraceptive methods?



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Thalomid-2 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Yes No

Q8. Prescriber may provide any supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other additional clinical information to support an authorization request).

Q9. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Topical Immunosuppressants-1

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign: (* Mandatory Questions)

Q1. Is this request for initial or continuing therapy?

Initial therapy

Continuing therapy (Start date MM/YY):

Q2. Please indicate the patient's diagnosis for the requested medication: *

Atopic dermatitis Other

Q3. If the patient's diagnosis is OTHER, please specify:

Q4. Please indicate which medication this request is for:

Elidel Cream 1%

Tacrolimus Ointment 0.03%

Tacrolimus Ointment 0.1%

Q5. Please indicate the patient's age:

Under 2 years of age

2-15 years of age

16 years of age or older

Q6. Has the patient tried and failed at least TWO (2) medium or higher potency topical steroids?

Yes No

Q7. If the patient has NOT tried at least TWO (2) medium or higher potency topical steroids, is there a reason these medications cannot be used (i.e. contraindication, history of adverse event, etc)?

Yes (please explain):

No

Q8. Has the patient been advised that Elidel and tacrolimus should only be used to treat the immediate problem and then should be stopped when the condition improves?

Yes No



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Topical Immunosuppressants-1

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Q9. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Tracleer-2 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial

Continuing (Start date MM/YY):

Q2. Is Tracleer being used to treat (PAH) Pulmonary Arterial Hypertension, with diagnosis confirmed by right heart catheterization and NYHA Class II-IV symptoms?

Yes No

Q3. If answer is no, please indicate diagnosis:

Q4. If the patient is a female of childbearing potential, will she use more than one method of contraception concurrently?

Yes No Not applicable

Q5. Do any of the following apply for this patient: AST/ALT level greater than 3 times upper limit of normal (ULN) OR pregnancy OR concomitant use of cyclosporine A or glyburide?

Yes No

Q6. Prescriber may provide any supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other additional clinical information) to support an authorization request.

Q7. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Tysabri-2 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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, Member Number, Date of Birth, Group Number, Address, City, State, Zip, Member Phone, Prescriber Name, Fax, Office Contact, NPI, Address, City, State, Zip, Phone, State Lic ID

Drug Name: Expedited/Urgent

Directions:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign: (* Mandatory Questions)
Q1. Is this request for initial or continuing therapy?
Q2. Please indicate the diagnosis for which the requested medication is being prescribed: *
Q3. Will Tysabri be used as monotherapy?
Q4. FOR MULTIPLE SCLEROSIS: Has the patient had an inadequate response or intolerance to other MS therapies?
Q5. FOR CROHN'S DISEASE: If the patient has received prior therapy with Tysabri, has the patient's condition improved or stabilized on treatment?
Q6. Please list all other medications the patient has previously tried for the indicated diagnosis along with the dates and outcomes (e.g. ineffective, adverse reaction, etc)
Q7. IF THE REQUEST IS FOR OFF-LABEL USE you must provide a unique peer-reviewed journal article to support therequest. Please attach any medical information that may support approval.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Tyzeka- 2 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Please indicate the diagnosis for which the requested medication is being prescribed:

Chronic Hepatitis B (HBV)

Other (please specify):

Q2. Does the patient have evidence of a positive HBsAg (+ or -) serological marker for greater than 6 months OR evidence by a liver biopsy showing chronic hepatitis?

Yes No

Q3. Please provide the most recent HB viral titer

Q4. Does the patient have elevations in liver aminotransferases (ALT or AST) that are two (2) times greater than normal OR normal liver aminotransferase (ALT or AST) levels with evidence of significant disease found on biopsy?

Yes No

Q5. Is the patient HIV(+)?

Yes No

Q6. Is the patient 16 years of age or older?

Yes No

Q7. Is the patient receiving concurrent therapy with Baraclude, Epivir and/or Intron A?

Yes No

Q8. If this is continuing therapy with Tyzeka, is there documented clinical improvement shown by a drop in viral load or reduction in the patient's liver aminotransferases?

Yes No

Q9. Is the prescribing physician an Infectious Disease specialist OR Gastroenterologist OR affiliated with an infectious disease or gastroenterology practice OR a primary care physician with experience in treating HBV?

Yes No

Q10. MANDATORY: Please submit chart notes documenting diagnosis, serological markers or liver biopsy, viral load, and



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Tyzeka- 2 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

liver aminotransferases lab values.

Q11. Prescriber may provide any supporting clinical statements (such as adverse outcomes, treatment failures, or any other additional clinical information to support an authorization request).

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Vimpat- 1 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial therapy

Continuing therapy (Start date MM/YY):

Q2. What is the patient's diagnosis for the requested medication?

Partial-onset seizures

Other

Q3. If the diagnosis is OTHER, please specify?

Q4. Prescriber may provide any supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other additional clinical information) to support an authorization 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Vpriv- 2 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial therapy

Continuing therapy (Start date MM/YY):

Q2. Please indicate the patient's diagnosis for the requested medication:

Gaucher disease Other

Q3. If the patient's diagnosis is OTHER, please specify:

Q4. Has the diagnosis been confirmed by bone marrow histology, DNA testing, or measurement of beta-glucocerebrosidase enzyme activity of less than 30 percent?

Yes No

Q5. Does the patient have at least one of the following conditions as a result of Type 1 Gaucher disease (please select all that apply)?

Anemia

Thrombocytopenia

Bone disease

Hepatomegaly

Splenomegaly

None of the above

Q6. For CONTINUING THERAPY (24 months or greater), has the patient experienced any of the following (please select all that apply)?

A decrease in liver and spleen volume

An increase in platelet count

An increase in hemoglobin concentration

None of the above



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Vpriv- 2 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Q7. Will Vpriv be used in combination with miglustat (Zavesca)?

Yes No

Q8. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Xenazine- 2 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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: Member Number: Date of Birth: Group Number: Address: City, State, Zip: Member Phone: Prescriber Name: Fax: Office Contact: NPI: Address: City, State, Zip: Phone: State Lic ID:

Drug Name: Expedited/Urgent

Directions:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign: (* Mandatory Questions) Q1. Is this request for initial or continuing therapy? Q2. Please indicate the patient's diagnosis for treatment: * Q3. If the patient's diagnosis is OTHER, please specify: Q4. Which of the following apply to this patient (check all that apply)? * Q5. Prescriber may provide any supporting clinical statements... Q6. IF THE REQUEST IS FOR OFF-LABEL USE you must provide a unique peer-reviewed journal article...

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Xgeva-2

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial therapy

Continuing therapy (Start date MM/YY):

Q2. Please indicate the patient's diagnosis for the requested medication:

Bone metastases from solid tumors

Giant cell tumor of the bone that is unresectable or where surgical resection is likely to result in severe morbidity

Hypercalcemia of malignancy refractory to bisphosphonate therapy

Other

Q3. If the patient's diagnosis is OTHER, please specify:

Q4. Will the patient receive concurrent calcium and vitamin D supplementation as needed?

Yes No

Q5. Does the patient have uncorrected hypocalcemia?

Yes No

Q6. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Xifaxan- 3 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign>(* Mandatory Questions)

Q1. Is this request for initial or continuing therapy?

Initial Therapy

Continuing (Start date MM/YY):

Q2. Which Strength of Xifaxan is being requested? *

Xifaxan 200mg

Xifaxan 550mg

Q3. Please indicate the patient's diagnosis below:

Hepatic encephalopathy

Traveler's Diarrhea

Other

Q4. If the patient's diagnosis is OTHER, please specify:

Q5. Is the patient 19 years of age or older?

Yes

No

Q6. Please list all other medications the patient has previously tried for the indicated diagnosis along with the dates and outcomes (e.g. ineffective, adverse reaction, etc)

Q7. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Xolair-3 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial

Continuing (Start date MM/YY):

Q2. Is the patient age 12 or older?

Yes No

Q3. Is the prescriber a pulmonologist, immunologist, or allergist?

Yes No

Q4. Please indicate the diagnosis for which the requested medication is being prescribed:

Moderate-to-severe, persistent allergic asthma

Other (please specify):

Q5. Does the patient have evidence of reversible disease (demonstrates at least 20 percent improvement in PEF with a short-acting bronchodilator challenge)?

Yes No

Q6. Has the patient experienced two or more asthma exacerbations per month within the last three months?

Yes No

Q7. Has the patient had a positive skin test to at least one perennial aeroallergen?

Yes No

Q8. Is the patient's baseline IgE level at or above 30 IU/mL?

Yes No

Q9. Is the patient's asthma inadequately controlled despite adherent use of inhaled corticosteroids?

Yes No

Q10. Has the patient had an inadequate response to a trial of a leukotriene modifier or long-acting beta2-agonist (unless patient demonstrates intolerance to the therapeutic trial)?

Yes No



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Xolair-3 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Q11. FOR CONTINUATION THERAPY: Has the patient demonstrated an improvement in asthma control with use of Xolair?

Yes No

Q12. Prescriber may provide any additional supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other clinical information to support this request).

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Xtandi-1

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial

Continuing (Start date MM/YY):

Q2. Please indicate the patient's diagnosis for the requested medication below:

Prostate Cancer (metastatic, castration-resistant)

Other

Q3. If the patient's diagnosis is OTHER, please specify:

Q4. Has the patient tried and failed DOCETAXEL?

Yes

No

Q5. If the patient has not tried DOCETAXEL, is there a reason this medication cannot be used (i.e. contraindication, history of adverse event, etc)?

Yes (Please Explain):

No

Q6. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Xyrem-3 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial

Continuing (Start date MM/YY):

Q2. Please indicate the diagnosis for which the requested medication is being prescribed, below:

Narcolepsy Other

Q3. If diagnosis is OTHER, please describe

Q4. Does the patient have excessive daytime sleepiness with symptoms that limit their ability to perform normal daily activities?

Yes No

Q5. Does the patient have cataplexy (a condition characterized by weak or paralyzed muscles)?

Yes No

Q6. Is the patient also taking/receiving any of the following: anxiolytics, sedatives, hypnotics, barbiturates, benzodiazepines or ethanol?

Yes No

Q7. FOR CONTINUATION THERAPY: Has the patient experienced a decrease in daytime sleepiness and/or cataplexy?

Yes No

Q8. Please provide any supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other additional clinical information) to support an authorization request.

Q9. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Zavesca-3 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial

Continuing (Start date MM/YY):

Q2. Is the patient 18 years or older?

Yes No

Q3. Please indicate the diagnosis for which Zavesca is being prescribed:

Gaucher disease

Other (please specify):

Q4. Does the patient have any of the following conditions: pregnancy or severe renal impairment?

Yes No

Q5. Has the diagnosis been confirmed by bone marrow histology, DNA testing or measurement of b-glucocerebrosidase enzyme activity less than 30%?

Yes No

Q6. Has the patient had a trial of enzyme replacement therapy (ERT) or ERT is not a therapeutic option (eg, allergy, poor venous access)?

Yes No

Q7. Is the patient a female of child bearing age?

Yes No

Q8. If yes, has this female patients of childbearing age been educated about the potential hazards associated with Zavesca use in pregnancy (ie, potential harm to fetus)?

Yes No

Q9. Has the patient previously received 24 months of Zavesca therapy?

Yes No

Q10. If yes, has the patient shown a decrease in liver and spleen volume and/or increases in platelet count and/or increases in hemoglobin concentration?



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Zavesca-3 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Yes No

Q11. If yes, has the patient shown a decrease in liver and spleen volume and/or increases in platelet count and/or increases in hemoglobin concentration?

Yes No

Q12. Prescriber may provide any additional supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other clinical information to support this request).

Q13. 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

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Zorbtive- 1 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Is this request for initial or continuing therapy?

Initial

Continuing (Start date MM/YY):

Q2. Please indicate the patient's diagnosis for treatment:

Short Bowel Syndrome

Other (please specify):

Q3. Does the patient have any of the following: Active malignancy, acute critical illness due to complications following open heart or abdominal surgery, accidental trauma or respiratory failure?

Yes No

Q4. FOR CONTINUING THERAPY: Has the patient shown a response to Zorbtive therapy (e.g., requirements for nutritional support have decreased or the patient's weight has stabilized or increased)?

Yes No

Q5. Please provide any supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other additional clinical information to support an authorization request)

Q6. 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.

Physician Signature

Date



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Zytiga- 1 Medicare

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS 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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign: (* Mandatory Questions)

Q1. Is the request for initial or continuing therapy?

Initial

Continuing (Start date MM/YY):

Q2. Please indicate the patient's diagnosis for treatment with Zytiga: *

Castration-resistant, metastatic prostate cancer

Other

Q3. If the patient's diagnosis is OTHER, please specify:

Q4. Will Zytiga be used combination with prednisone?

Yes No

Q5. Has the patient received prior chemotherapy containing docetaxel?

Yes No

Q6. Prescriber may provide any supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other additional clinical information to support an authorization request)

Q7. 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.

Physician Signature

Date