

>>> Please **DO NOT USE** this form for Specialty and/or Biopharmaceutical Requests <<<

**Submit the request by sending the completed form to Envolve Pharmacy Solutions by FAX @  
1-866-399-0929 or MAIL to Envolve Pharmacy Solutions c/o Prior Authorization Department at  
5 River Park Place East, Suite 210, Fresno, CA 93720**

I. MEMBER INFORMATION		II. PRESCRIBER INFORMATION	
Name:		Name:	
ID Number:		Specialty:	
Gender:		NPI or DEA Number:	
Date of Birth:		Group or Hospital:	
Address:		Address:	
City, State, Zip:		City, State, Zip:	
Primary Phone:		Phone:	
Alternate Phone:		Fax:	
Medication Allergies:		Office Contact Name:	
III. MEDICATION REQUESTED (one medication request per form)			
Drug Name:		Dosage/Strength:	
Dosage Form:		Route of Admin:	
Quantity Per Day:		Directions:	
Refills/Length of Tx:		Therapy Start Date:	
IV. DIAGNOSIS (as relevant to this request)			
Diagnosis:		ICD9 and Description:	
Date of Diagnosis:		NOTE: Include diagnostic clinicals (labs, radiology, etc.).	
V. MEDICATION HISTORY (for this diagnosis)			
A. Is the member currently on this medication? <input type="checkbox"/> Yes; how long? _____ <input type="checkbox"/> No; skip to items B&C, go to D.			
B. Is this a request for continuation of a previous approval? <input type="checkbox"/> Yes; go to item C. <input type="checkbox"/> No; skip item C, go to D.			
C. Has the strength, dosage, or quantity required per day: <input type="checkbox"/> INCREASED <input type="checkbox"/> DECREASED <input type="checkbox"/> Remained the SAME			
D. Indicate PREVIOUS medications treatment/outcomes below. <span style="color: red; font-weight: bold;">NOTE: Confirmation will be made using claims history.</span>			
	Drug Name, Strength, and Dosage	Dates of Therapy	Reason for Discontinuation
1			
2			
3			
4			
VI. RATIONALE FOR REQUEST and PERTINENT CLINICAL INFORMATION			
NOTE: Appropriate clinical information to support this request is required for all PA's. Attach additional sheets if more space is needed.			
<input type="checkbox"/> Medical intolerance to the preferred drug. Provide clinical symptoms. <input type="checkbox"/> Inadequate response to the preferred drug. <input type="checkbox"/> Absence of appropriate formulation or indication of the drug. Please specify. <input type="checkbox"/> Clinically unacceptable risk with a change in therapy to a preferred drug. <input type="checkbox"/> Other – Provide rationale for the request.			

Prescriber Signature – **Dispense as Written (DAW):**

Prescriber Signature – **Substitution Permitted:**

**X** \_\_\_\_\_ Date: \_\_\_\_\_

**X** \_\_\_\_\_ Date: \_\_\_\_\_

Please access <http://www.NHhealthyfamilies.com/> or contact provider services for a current listing of preferred products. A response will be provided via fax or phone within 24 hours of the receipt of complete information. Incomplete and illegible forms will delay processing. Be sure to include lab reports with requests when appropriate. **To request a 72 hour emergency supply of medication you may call Envolve Pharmacy Solutions at 1-877-250-5227.** Requests can also be mailed to: Envolve Pharmacy Solutions, c/o Prior Authorization Department, 5 River Park Place East, Suite 210, Fresno, California 93720.

**CONFIDENTIALITY NOTICE:** This facsimile transmission is intended to be delivered only to the name addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the name addressee, except by express authority of sender to the name addressee.