Prior Authorization Request Form for Prescription Drugs

CoverMyMeds is Ambetter's preferred way to receive prior authorization requests.
Visit CoverMyMeds.com/EPA/EnvolveRx to begin using this free service.
OR Fax this completed form to 877.386.4695
OR Mail requests to: Envolve Pharmacy Solutions PA Dept. | 5 River Park Place East, Suite 210 | Fresno, CA 93720

I. Provider Information	II. Member Information
Prescriber name (print):	Member name:
Office contact name:	Identification number:
Group name:	Group number:
Fax:	Date of birth:
Phone:	Medication allergies:

III. Drug Information *(One drug request perform)*

Drug name and strength:	Dosage form:	Dosage interval (sig):	Qty per day:
Diagnosis relevant to ***this*** request:		ICD-10 diagnosis code:	
Expected length of therapy:		Are you requesting a formulary or step-therapy exception? ❑Yes	

Medication History for this Diagnosis

A. Is member currently treated on this medication?

❑Yes, how long?_____ [Go to Item B] ❑No [Skip Items B & C, Go to Item D]

B. Is this request for continuation of a previous approval?

❑Yes [Go to Item C] ❑No [Skip Item C, Go to Item D]

C. Has strength, dosage, or quantity required per day increased or decreased?

❑Yes [Go to Item D] ❑No [Skip Item D, Indicate rationale for continuation in Section IV and submit form]

D. Please indicate previous treatment and outcomes below.

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

NOTE: Confirmation of use will be made from member history on file. Prior use of preferred drugs is a part of the exception criteria. The **Ambetter Formulary** is available on the Ambetter website at **www.ambetterhealth.com** (Search for your state to view your specific formulary document).

IV. Rationale for Request / Pertinent Clinical Information (Required for all Prior Authorizations)

Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	Provider Signature:	Date:

Envolve Pharmacy Solutions will respond via fax or phone within the time frame designated by your state's prior authorization regulations and the ACA. Requests for prior authorization (PA) requests must include member name, ID# and drug name. Incomplete forms will delay processing. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity, Hemoglobin A1C, Serum Creatinine, CD4, Hematocrit, WBC, etc.)