PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

CFI Non Formulary Exception

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:**	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State, Zip:	City, State, Zip:	
Member Phone:		

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 therapy ☐ Continuing therapy

Q2. What is the patient's diagnosis?

Q3. What is the anticipated duration of therapy?
☐ Less than a month
☐ One to three months
☐ Three months to one year
☐ Lifetime

Q4. Have other formulary alternatives in this drug category/class been tried and failed?
☐ Yes ☐ No

Q5. Please list them below along with the date the medication was tried and failed

Q6. If the patient is unable to tolerate the formulary alternative, what is the issue the patient is having?
☐ The patient has an allergy to the formulary alternative
☐ Other

Q7. Please define "other"

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

Q9. 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

Physician Signature **Date**