



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Virginia Premier Quantity Limit 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:

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. What is the patient's diagnosis

Q2. What is the quantity being requested and per how many days supply (e.g., 30 days supply)?

Q3. Is the drug being requested initial therapy or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q4. Have other formulary alternatives in this drug category/class been tried and failed?

☐ Yes ☐ No ☐ Unknown

Q5. If yes, please list the medication(s) and the date(s) of the trial and failure below:

Q6. Please provide details below regarding why the patient requires a Quantity Limit Exception:

Q7. What is the anticipated duration of therapy?

☐ Less than one month
☐ One to three months
☐ Three month to one year
☐ Lifetime

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

Physician Signature

Date