PRIOR AUTHORIZATION REQUEST FORM

Well Sense 9.080 Non-Preferred Drugs WellSense
Non-Preferred Drugs
Version 2.0
Effective 9/1/19

Phone: 877-957-1300 Fax back to: 866-305-5739

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/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

☐ Expedited/Urgent

Drug Name and Strength:
Directions / SIG:

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

Q2. Is the requested medication excluded from the plan's benefit?
☐ Yes ☐ No

Q3. Is the request for a Brand-name medication with an available AB-rated generic equivalent?
☐ Yes ☐ No ☐ Unknown

Q4. Please indicate the patient's diagnosis that requires treatment with the requested medication.

Q5. Does the patient have an allergy, contraindication, adverse reaction or poor response to all the medications within the same class on the preferred drug list?
☐ Yes ☐ No ☐ Unknown

WELL SENSE HEALTH PLAN

ENVISIONRx

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Q6. If YES, please indicate the medications and the reason each is unable to be used for the patient's diagnosis.

Q7. Does the patient have an indication that is unique to the non-preferred agent (including age-specific indication)?

☐ Yes ☐ No ☐ Unknown

Q8. If YES, please indicate the unique indication.

Q9. Is there a clinically unacceptable risk with using the covered alternative medications?

☐ Yes ☐ No ☐ Unknown

Q10. If YES, please indicate the unacceptable risk.

Q11. FOR BRAND NAME MEDICATIONS WITH AB RATED GENERICS, does the patient have an allergy to one of the inactive ingredients found in the generic but not in the brand?

☐ Yes ☐ No

Q12. FOR BRAND NAME MEDICATIONS WITH AB RATED GENERICS, has the patient had a poor response or cannot take at least 2 of the covered alternatives in the same therapeutic class?

☐ Yes ☐ No

Q13. For CONTINUING therapy, is the initial criteria met?

☐ Yes ☐ No

Q14. For CONTINUING therapy, is there a clinically unacceptable risk with a change in therapy to a covered agent?

☐ Yes ☐ No

Q15. For CONTINUING therapy, is there continued compliance with the requested therapy and the clinical condition has improved or stabilized without treatment related adverse effects?

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☐ Yes	☐ No
Q16. If coverage of medication is approved, how will this medication be supplied? (Please check one) ☐ Order through Plan Preferred Pharmacy	☐ Provider/Hospital Buy & Bill
Q17. If Buy and Bill, please provide the following information: J-codes:	
Q18. If Buy and Bill, please provide the following information: Procedure Codes:	
Q19. If Buy and Bill, please provide the following information: Number of Units and Visits:	
Q20. If Buy and Bill, please provide the following information: Date of Planned administration:	

Prescriber Signature

Date