PRIOR AUTHORIZATION REQUEST FORM

Well Sense 9.015 Age and Quantity Limitation Program
Quantity Limitation Program
Version 20.0
Effective Date 10/1/2020

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. If coverage of this medication is approved, then how will it be supplied? ☐ Plan Preferred Pharmacy ☐ Provider/Hospital Buy & Bill
Q2. BUY & BILL: Please write the J Code(s).
Q3. BUY & BILL: Please write the Procedure Code(s).
Q4. BUY & BILL: Please write the Number of Units.
Q5. BUY & BILL: Please write the Number of Visits.
Q6. BUY & BILL: Please write the Date of Administration.

WELL SENSE HEALTH PLAN

ENVISIONRx

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Q7. Is the request for initial or continuing therapy?

☐ Initial ☐ Continuing

Q8. For continuing therapy, please specify start date (MM/YY):

Q9. Please indicate the patient's diagnosis:

Q10. Please provide the quantity being requested per the day supply (i.e. 8 tablets per 30 days supply):

Q11. Can the daily dose required be achieved with commercially available dosage strengths and dosage forms?

☐ Yes ☐ No ☐ Unknown

Q12. Does the member require dosage titration that cannot be achieved with commercially available dosage strengths and forms within the quantity limit (up to 3 months)?

☐ Yes ☐ No ☐ Unknown

Q13. Does the patient have a need for a dosage regimen, drug strength, amount, or duration of therapy greater than what is recommended by the Food and Drug Administration (FDA) or covered by the plan?

☐ Yes ☐ No ☐ Unknown

Q14. Is the member tolerating medication at a lower dose or shorter duration of therapy without experiencing adverse effects?

☐ Yes ☐ No or Unknown

Q15. If no or unknown please provide a clinical rationale why the medication has not been tried at a lower dose.

Q16. Has the member had an inadequate response to the same medication at a lower dose or shorter duration?

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☐ Yes	☐ No or Unknown
Q17. Does the prescriber attest that the inadequate response is NOT due to medication non-adherence? ☐ Yes	☐ No
Q18. Please document the supporting rationale for this dosage regimen:	
Q19. For Continuation of therapy does the pharmacy claims history show compliance with medication regimen? ☐ Yes	☐ No

Prescriber Signature _____ Date _____