



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 (i	f applicable):
Drug Name and Strength: Directions / SIG:	☐ Expedited/U	Irgent
Please attach any pertinent medical history or information following qu	n for this patient that ma	y support approval. Please answer the
Q1. If coverage of this medication is approved, then how vertical transfer of the coverage of	will it be supplied?	
☐ Plan Preferred Pharmacy	☐ Provider/Hosp	ital 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	n.	

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Patient Name:	Prescribe	er Name:
Q7. Is the request for initial	or continuing therapy?	
☐ Initial		Continuing
Q8. For continuing thera	py, please specify start date (MM/YY):	
Q9. Please indicate the pat	ient's diagnosis:	
Q10. Please provide the qu	rantity being requested per the day supp	ly (i.e. 8 tablets per 30 days supply):
Q11. Can the daily dose red	quired be achieved with commercially av	vailable 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 tolerati	ng medication at a lower dose or shorte	r duration of therapy without experiencing adverse
☐ Yes		No or Unknown
Q15. If no or unknown pl	ease 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 me	edication at a lower dose or shorter duration?

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Patient Name:	Prescriber Name:
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 suppo	rting rationale for this dosage regimen:
Q19. For Continuation of therapy	does the pharmacy claims history show compliance with medication regimen?
Yes	□ No
Prescriber Sign	ature Date