PRIOR AUTHORIZATION REQUEST FORM

Well Sense 9.087 Step Therapy Exceptions
Step Therapy Exceptions
Version 1.0
Effective Date 9/10/18

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 therapy or continuing therapy? ☐ Initial Therapy ☐ Continuing Therapy
Q2. For continuing therapy, please indicate the initial start date of therapy (MM/YY):
Q3. Please list the patient's diagnosis related to the medication requested.
Q4. Indicate any previous medications that the patient has tried in the past and had an inadequate response, intolerance or has a contraindication to use.

Prescriber Signature _____ Date _____

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