BOSTON MEDICAL CENTER HEALTHNet PLAN

ENVISIONRx

PRIOR AUTHORIZATION REQUEST FORM

BMCHPQHP Standard Form
Massachusetts Standard Form for Medication Prior Authorization Requests

Phone: 888-566-0008 **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 continuation of therapy?

☐ Initial ☐ Continuing Therapy

Q2. If Continuing therapy, what date was the therapy initiated? (MM/YY)

Q3. What is the primary diagnosis related to the medication request?

Q4. What is the reason for the request?

☐ Prior Authorization, Step Therapy, Formulary Exception
☐ Quantity Exception
☐ Specialty Drug
☐ Other

Q5. If OTHER, please describe.

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Q6. What is the date the therapy will be initiated?

Q7. Is there a dispense as written specification?

☐ Yes ☐ No

Q8. If YES, please indicate the rationale.

Q9. Is the medication a compound?

☐ Yes ☐ No

Q10. If it is a compound, please list the ingredients:

Q11. For compound or off label use, please include citation to peer reviewed literature.

Q12. Please list any pertinent comorbidities.

Q13. Please list the patient's Height and Weight.

Q14. Please list any concurrent medications.

Q15. Which of the following opioid management tools are in place:

- ☐ Risk assessment
- ☐ Treatment Plan
- ☐ Informed Consent
- ☐ Pain Contract
- ☐ Pharmacy/Prescriber Restriction

Q16. Please list any therapies that have been tried/failed.

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Q17. Does the patient have contraindications to any alternative therapies? ☐ Yes ☐ No
Q18. If yes, please describe.
Q19. Were any nonpharmacologic therapies tried? ☐ Yes ☐ No
Q20. If yes, please describe.
Q21. Please list any relevant lab values.
Q22. If continuing therapy, has the patient shown improvement in related condition while on therapy? ☐ Yes ☐ No
Q23. Please provide the following information if the prescribers office will be supplying the medication to the patient (Buy and Bill): J-Codes:_____ Procedure codes(s) for administration:_____ Number of units and visits:_____Date of planned adminstration:_____

_____ _____

Prescriber Signature Date

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