

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Samaritan Non Formulary Excep/Prior Auth Excep

Phone: 800-832-4580 Fax back to: 877-502-9254

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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:Ph

Pharmacy Name:

Expedited/Urgent

Pharmacy Fax:

Pharmacy Phone:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following and sign: THIS FORM MUST BE COMPLETELY FILLED OUT.

Q1. Please provide the medication name and strength, directions, quantity, day supply and number of refills being requested.

Q2. What is this patient's diagnosis?

Q3. What is the anticipated duration of therapy?

- Less than a month
- One to three months
- Three months to one year
- Lifetime

Q4. Have other formulary alternatives in this drug category/class been tried and failed? Please list them below along with the date and the medication was tried and failed.

Yes No

Q5. If the patient is unable to tolerate the formulary alternative, what is the issue the patient is having? Please provide any supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other additional clinical information to support a formulary exception request).

Physician Signature

Date