Reset Form | Print Form

MEDICATION PRIOR AUTHORIZATION REQUEST FORM
FAX this completed form to 1-888-865-6531
OR Mail request to: Envolve Pharmacy Solutions Prior Authorization Dept.
5 River Park Place East, Suite 210 | Fresno, CA 93720

Call 1-833-705-1351 to request a 72-hour supply of medication. For Buy and Bill requests, FAX to 1-833-823-0001. Envolve Pharmacy Solutions will respond via fax or phone within 24 hours of receipt of all necessary information, except during weekends and holidays. For immediate response on weekends and holidays,NurseWise will answer your call.

Children's Medical Services Health Plan
OPERATED BY SUNSHINE HEALTH

envolve Pharmacy Solutions

Exondys 51® (eteplirsen)

(Note: Maximum Length of Approval is 6 Months)

Note: Form must be completed in full.

Recipient's Medicaid ID#

Date of Birth (MM/DD/YYYY) ___ / ___ / ____

Recipient's Full Name

Prescriber's Full Name

Prescriber's NPI

Prescriber Phone Number ___ - ___ - ____

Prescriber Fax Number ___ - ___ - ____

MEDICATION	QUANTITY	DIRECTIONS

Weight _____ **lbs or** _____ **kgs as of** _____ **(date)**

Diagnosis _____

Provider Specialty _____

☐ **Initiation of Therapy** **OR** ☐ **Continuation of Therapy**

NOTE: OFFICIAL LAB REPORTS AND TESTING MUST BE SUBMITTED WITH THE PRIOR AUTHORIZATION REQUEST. FORM AND LAB DATA MUST BE COMPLETED IN FULL.

Official Genetic Testing Confirming Diagnosis:
☐ **Yes** ☐ **No**
Date of Test: _____

Six-Minute Walk Test:
☐ **Yes** ☐ **No**
Date of Test: _____

Brooke Upper Extremity Function Scale:
☐ **Yes** ☐ **No**
Date: _____

Forced Vital Capacity:
☐ **Yes** ☐ **No**
Date: _____

Prescriber's Signature: _____ **Date:** _____

REQUIRED FOR REVIEW: Copies of medical records (e.g., diagnostic evaluations and recent chart notes), and the most recent copies of related labs. The provider must retain copies of all documentation for five years.