MEDICATION PRIOR AUTHORIZATION REQUEST FORM

FAX this completed form to 1-888-865-6531

OR Mail request to: Envolve Pharmacy Solutions PA Dept. | 5 River Park Place East, Suite 210 | Fresno, CA 93720

Call 1-833-705-1351 to request a 72-hour supply of medication.

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.

ORAL ONCOLOGY AGENTS
(Maximum Approval= One Year)
Note: Form must be completed in full. An incomplete form may be returned.

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** ☐☐☐ - ☐☐☐ - ☐☐☐☐

Provider Specialty: ______________________________

Medication Request: **New** **Continuation** **Ht:** ______ in ______ cm **Wt:** ______ lb ______ kg **BSA:** ______

1. **Medication Requested:**

Medication	Strength	Directions	# of Cycles	Quantity/Month

2. **Diagnosis**

☐ Breast Cancer ☐ Renal Cancer ☐ Prostate Cancer ☐ Lung Cancer ☐ Ovarian Cancer

☐ Leukemia ☐ Other Diagnosis: ______________________________

3. **Previous Medication Trials**

Medication	Strength	Directions	Start/End Dates	Maximum Dose (Per Day)

4. **List all other medications the patient is taking concurrently with the antineoplastic:**

Medication	Strength	Directions	# of Cycles

PRESCRIBER'S SIGNATURE DATE

REQUIRED FOR REVIEW: Copies of medical records (i.e. 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.

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