sunshine health

envolve Pharmacy Solutions

MEDICATION PRIOR AUTHORIZATION REQUEST FORM

Is the request for a **NON-SPECIALTY MEDICATION DISPENSED BY A PHARMACY**?

☐ **YES** → Complete **THIS** form and FAX to **1-866-399-0929**

☐ **NO** → Do **NOT** use this form. Complete the Drug-Specific Form (Link) form OR the Prior Authorization Form - Specialty Pharmacy and Buy & Bill Form (Link).

TODAY'S DATE: _____

I. MEMBER INFORMATION *(*REQUIRED FIELDS)*		**II. PRESCRIBER INFORMATION** *(*REQUIRED FIELDS)*	
***Name:**		***Name:**	
ID Number:		Specialty:	
Gender:		***NPI or DEA**	
***Date of**		Group or	
Address:		Address:	
City, State, Zip:		City, State, Zip:	
Primary		***Phone:**	
Alternate		***Fax:**	
Medication		Office Contact	

III. Drug Information *(only ONE drug request per form)*		*(*REQUIRED FIELDS)*	
*Drug Name:		*Strength:	
*Dosage Form:			
*Directions for Use:			
*Therapy Start Date:		* Therapy End Date:	

IV. DIAGNOSIS *(as relevant to this request)*		(*REQUIRED FIELDS)	
Diagnosis:		***ICD10:**	
Date of Diagnosis:		*NOTE: Include diagnostic clinicals (labs, radiology, etc.).*	

V. MEDICATION HISTORY (for this diagnosis)

A. Is the member currently on this medication? ☐Yes; if yes, how long?_____ ☐No; if no, skip items B&C, go to D.

B. Is this a request for continuation of a previous approval? ☐Yes; if yes, go to item C. ☐No; if no, skip item C, go to D.

C. Has the strength, dosage, or quantity required per day: ☐INCREASED:_____ ☐DECREASED:_____ ☐Remained the

D. Indicate PREVIOUS medications treatment/outcomes below. *NOTE: Confirmation will be made using claims history.*

	Drug Name, Strength, and Dosage	**Dates of**	**Reason for**
1			
2			
3			
4			

VI. RATIONALE FOR REQUEST and PERTINENT CLINICAL INFORMATION

NOTE: Appropriate clinical information to support this request is required for all PA's. Attach additional sheets if more space is needed.

Prescriber Signature – Dispense as Written (DAW):

X_____ **Date:**_____

Prescriber Signature – Substitution Permitted:

X_____ Date: _____

Please access www.SunshineHealth.com or contact provider services for a current listing of preferred products. Incomplete and illegible forms will delay processing. Be sure to include lab reports with requests when appropriate.

To request a 72 hour emergency supply of medication you may call Envolve Pharmacy Solutions at (877) 397-9526. *NOTE: The 72 hour supply does not apply to specialty medications.*

Requests can also be mailed to: Envolve Pharmacy Solutions, Attention: Prior Authorization Department, 5 River Park Place East, Suite 210, Fresno, California 93720.

****REQUIRED FIELDS - PA requests with missing/incomplete required fields may be returned as an invalid request. Valid requests also require appropriate clinical documentation to support the medical necessity of this request.***