

**MEDICATION PRIOR AUTHORIZATION REQUEST FORM
MANAGED HEALTH SERVICES (MHS)**



(Please DO NOT USE this form for Specialty and/or Biopharmaceutical Requests)

FAX this completed form to (833) 645-2742

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

I. MEMBER INFORMATION		II. PRESCRIBER INFORMATION	
Name:		Name:	
ID Number:		Specialty:	
Gender:		NPI or DEA Number:	
Date of Birth:		Group or Hospital:	
Address:		Address:	
City, State, Zip:		City, State, Zip:	
Primary Phone:		Phone:	
Alternate Phone:		Fax:	
Medication Allergies:		Office Contact Name:	
III. MEDICATION REQUESTED (one medication request perform)			
Drug Name:		Dosage/Strength:	
Dosage Form:		Route of Admin:	
Quantity Per Day:		Directions:	
Refills/Length of Tx:		Therapy Start Date:	
IV. DIAGNOSIS (as relevant to this request)			
Diagnosis:		ICD9 and Description:	
Date of Diagnosis:		<i>NOTE: Include diagnostic clinicals (labs, radiology, etc.).</i>	
V. MEDICATION HISTORY (for this diagnosis)			
A. Is the member currently on this medication? <input type="checkbox"/> Yes; how long? _____ <input type="checkbox"/> No; skip items B&C, go to D.			
B. Is this a request for continuation of a previous approval? <input type="checkbox"/> Yes; go to item C. <input type="checkbox"/> No; skip item C, go to D.			
C. Has the strength, dosage, or quantity required per day: <input type="checkbox"/> INCREASED <input type="checkbox"/> DECREASED <input type="checkbox"/> Remained the SAME			
D. Indicate PREVIOUS medications treatment/outcomes below. <i>NOTE: Confirmation will be made using claims history.</i>			
Drug Name, Strength, and Dosage		Dates of Therapy	Reason for Discontinuation
1			
2			
3			
4			
VI. RATIONALE FOR REQUEST and PERTINENT CLINICAL INFORMATION			
<i>NOTE: Appropriate clinical information to support this request is required for all PA's. Attach additional sheets if more space is needed.</i>			
<input type="checkbox"/> Medical intolerance to the preferred drug. Provide clinical symptoms. <input type="checkbox"/> Inadequate response to the preferred drug. <input type="checkbox"/> Absence of appropriate formulation or indication of the drug. Please specify. <input type="checkbox"/> Other-Provider rationale for the request.			

Prescriber Signature – Dispense as Written (DAW):

Prescriber Signature – Substitution Permitted:

X _____ Date: _____

X _____ Date: _____

Please access mhsindiana.com or contact Provider Services for a current listing of preferred products. A response will be provided via fax or phone within one business day of the receipt of the complete information. 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 (855) 772-7125. NOTE: The 72 hour supply does not apply to specialty medications.** Requests can also be mailed to: Envolve Pharmacy Solutions c/o Prior Authorization Department, 5 River Park Place East, Suite 210, Fresno, CA 93720 1021.PH.P.FO.1 12/21

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