nh healthy families

Phone: (866) 399-0928
Fax: (866) 399-0929

Send To: ❍ Envolve
Date: ___________________
Date Medication Required:____________________
Ship to: ❍ Physician ❍ Patient's Home ❍ Other _________

Prior Authorization Form
Specialty Drug

Patient Name: ____
Address: ____
City: ______________________________State: _______Zip:___________
Home Phone: (___________) ___________ - ____________________
Work Phone: (_______) ____________ - ______________________
Cell Phone: (__________) ____________ - _____________________
Patient Soc. Sec #: ________________ Allergies:_____________________
Date of Birth: ___/___/___ Sex: ❍ Male ❍Female Weight _____ ❍lbs ❍kg
Height: _______ BSA: ________ m² ❍See attached demographic sheet

Physician Name: ____
State Lic #_______________________ DEA # ______________________
NPI # _________________________ Specialty: ____________________
Practice Name/Hospital: _______________________________________
Address: ____
City: _________________________ State: ________ Zip: ___________
Physician's Ph: (__________) ___________ - ___________________
Physician's Fax: (__________) ___________ - ___________________
Nurse/Key Office Contact: ______________________________________

INSURANCE INFORMATION (Complete or Attach Copies of cards)

Primary Insurance:________________	Secondary Insurance:______________	Rx Card (PBM):__________________	Cardholder First Name: ___________
City:____________State:__________	City:____________State:__________	PBM BIN: _______________________	Last Name: ____________________
Plan #: ______________________	Plan #: ______________________	City:____________State:__________	Employer: _____________________
Group #: _____________________	Group #: _____________________	Group #: ______________________	ID #: ________________________
Phone: (_____) _______-_________	Phone: (_____) _______-_________	Phone: (_____) _______-_________	Group #: ______________________

DIAGNOSIS *(Required)*

What is the ICD 9 / ICD 10 code? ________________________

PATIENT EVALUATION

1. Is the member currently treated with this medication?
   ❑ Yes; if yes, please continue
   ❑ No; if no, please continue to question #4

2. How long has the patient been on treated with this medication: ____________ ❑ years ❑ months

3. Has the patient had a positive outcome? ❑ Yes ❑ No

4. Please indicate previous treatments and outcomes?

Drug Name (include strength and dosage)	Dates of Therapy	Reason for Discontinuation
1.		
2.		
3.		
4.		
NOTE: confirmation of use will be made from member history on file; prior use of preferred drugs is part of the exception criteria		

5. Please state Rationale for Request / Pertinent Clinical Information (Required for all prior authorizations)

****NOTE: We can NOT make a decision without a copy of pertinent lab results and/or the current clinical progress notes - Thank You****

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS

Physician's Signature: ___________________________________ ❍ DAW (Dispense as Written **Date**____/_____/____

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the name addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the name addressee, except by express authority of sender to the name addressee.