nh healthy families

Phone: (866) 399-0928
Fax: (833) 645-2738

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: _____
City: _____ State: _____
Plan #: _____
Group #: _____
Phone: (_____) _____ - _____

Secondary Insurance: _____
City: _____ State: _____
Plan #: _____
Group #: _____
Phone: (_____) _____ - _____

Rx Card (PBM): _____
PBM BIN: _____
City: _____ State: _____
Group #: _____
Phone: (_____) _____ - _____

Cardholder First Name: _____
Last Name: _____
Employer: _____
ID #: _____
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** ____/____/____