ambetter. FROM | sunshine health. Insured by Celtic Insurance Company

envolve™ Pharmacy Solutions

MEDICATION PRIOR AUTHORIZATION REQUEST FORM

Is the request for a **SPECIALTY MEDICATION** or **BUY & BILL**?

☐ **YES (Specialty Pharmacy Medication Request)** → Complete this form and fax to **(855) 678-6976**. For questions, call (800) 460-8988.

☐ **YES (Buy and Bill Medication Request)** → Complete this form and fax to **(866) 351-7388.** For questions, call (866) 796-0530, ext. 41919.

☐ **NO (Non-Specialty Medication Request)** → Do **NOT** Use this form. Complete the Prior Authorization Form - Non-Specialty Medication form on the Sunshine Health web-site (Click Here) and fax to **(866) 399-0929**. For questions, call (866) 399-0928.

TODAY'S DATE: _____

I. MEMBER INFORMATION *[*REQUIRED FIELDS]*	**II. PRESCRIBER INFORMATION** *[*REQUIRED FIELDS]*
***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:
Member's Height:	Additional Pertinent Provider Information:
Member's Weight: kg / lb (circle one)	

III. Drug Information *(only ONE drug request per form)* *[*REQUIRED FIELDS]*			
***HCPCS (if buy and bill):**		***Drug Name:**	
***Strength:**		***Dosage Form:**	
***Directions for Use (sig):**			
***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 same

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

Drug Name, Strength, and Dosage	Dates of Therapy	Reason for Discontinuation
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

X_____ Date:_____

Please access www.SunshineHealth.com or contact provider services for a current listing of preferred products.

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.