BOSTON MEDICAL CENTER HEALTHNet PLAN

ENVISIONRx

PRIOR AUTHORIZATION REQUEST FORM

BMCHP 9.080 Non-Preferred Drugs
Non-Preferred Drugs
Version 1.0
Effective 7/24/18

Phone: 888-566-0008 **Fax back to: 866-305-5739**

ENVISION RX OPTIONS manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for INITIAL or CONTINUING therapy?
☐ Initial Therapy ☐ Continuing Therapy

Q2. Is the requested medication excluded from the plan's benefit?
☐ Yes ☐ No

Q3. Is the request for a Brand-name medication with an available AB-rated generic equivalent?
☐ Yes ☐ No ☐ Unknown

Q4. Please indicate the patient's diagnosis that requires treatment with the requested medication.

Q5. Is the quantity of medication prescribed consistent with the dosing listed in the manufacturer labeling for the prescribed indication?

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Patient Name: **Prescriber Name:**

☐ Yes	☐ No	
Q6. Does the patient have an allergy, contraindication, adverse reaction or poor response to a trial of at least 4 preferred medications (if available)?		
☐ Yes	☐ No	☐ Unknown
Q7. If YES, please indicate the 4 medications and the reason each is unable to be used for the patient's diagnosis.		
Q8. Does the patient have an indication that is unique to the non-preferred agent (including age-specific indication)?		
☐ Yes	☐ No	☐ Unknown
Q9. If YES, please indicate the unique indication.		
Q10. Is there a clinically unacceptable risk with using the covered alternative medications?		
☐ Yes	☐ No	☐ Unknown
Q11. If YES, please indicate the unacceptable risk.		
Q12. If requesting a "convenience packing" or "polypill", has the patient had a treatment failure due to poor compliance with the individually prescribed covered medications in the same therapeutic class as those in the "convenience packing" or "polypill"?		
☐ Yes	☐ No	☐ Unknown
Q13. For BRAND-NAME medications, does the patient have an allergy to one of the inactive ingredients found in the generic version(s) of the medication that is not found in the Brand-name medication?		
☐ Yes	☐ No	
Q14. If YES, please indicate the ingredient and the reaction.		

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Q15. For BRAND-NAME medications, has the patient had a poor response or intolerance to a trial of at least 2 other covered alternatives (one if less than 2 available) within the same therapeutic class as the requested medication?

☐ Yes ☐ No

Q16. If Yes, please indicate the medication(s).

Q17. For CONTINUING therapy, is the initial criteria met?

☐ Yes ☐ No

Q18. For CONTINUING therapy, is there a clinically unacceptable risk with a change in therapy to a covered agent?

☐ Yes ☐ No

Q19. For CONTINUING therapy, is there continued compliance with the requested therapy and the clinical condition has improved or stabilized without treatment related adverse effects?

☐ Yes ☐ No

Prescriber Signature

Date

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