

Confidential

2181 E Aurora Rd Ste 201 Twinsburg OH 44087 Phone: 866-250-2005 Fax: 866-250-5178	<i>EnvisionRx Options</i>
To:	From: Envision Clinical Staff
Fax:	Pages: 3 inc. cover
Phone:	Date:
Re:	Medical Necessity Exception Request Form-

Envision Rx Options Provider,

Your patient _____, has

indicated that they need a medication exception for their drug

Comments:

Comments:

Please complete the form and fax back to 330-405-8081 attn: Clinical Dept

Thank you,
The Clinical Staff
Envision Pharmaceutical Services

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FOR ENVISION INTERNAL USE ONLY – Date and Time Received Completed form from Doctor

Information on this form is protected health information and subject to all privacy and security regulations under HIPAA. Prior Authorization of benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient.

Medical Necessity Request Confidential

Confidential
Envision Clinical Pharmacy Review
Fax Completed Form to: 330-405-8081 or call 330-405-8080

A separate request must be completed for each drug for each patient.

Patient Information			Physician Information	
Patient Name:			Name:	NPI#
Address:			Address:	
Member ID#	Group#	Carrier	Office Phone:	
Sex: M <input type="checkbox"/> F <input type="checkbox"/>		Date of Birth:	Secure Office Fax Number:	

Drug Name:				
Dose:		Directions:	Quantity:	
Diagnosis/Indication:			Anticipated Duration of Therapy:	
Initial Therapy? Y N	Continuing Therapy? Y N		Has Dose Been Titrated? Y N	
ICD 9 CODE:			J CODE:	
Please check all that apply: Please state why this medication is required: _____ _____ _____ _____ _____ _____ _____ _____ _____			PRIOR ALTERNATIVE TREATMENT(S): Please list therapies tried and failed in the past: 1. 2. 3. 4. 5.	
			SUPPORTING CLINICAL STATEMENT(REQUIRED): PHYSICIAN SIGNATURE (REQUIRED):	

Supporting Clinical Statement (such as applicable protocols or guidelines followed, contraindications, drug allergies, dialysis, or any other additional clinical information to support medication request):

Please note:

-Approvals will be for **twelve (12) months only**. Prior authorization will be required, with updated clinical information, after a twelve (12) month period.

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EnvisionRxOptions

pharmaceutical services **Rx** incorporated

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-ANY INFORMATION LEFT BLANK OR ILLEGIBLE MAY DELAY THE REVIEW PROCESS

Fax completed form to *EnvisionRx Plus* at 1-866-250-5178 or mail to *EnvisionRx Plus* 2181 E. Aurora Rd. Twinsburg, Ohio 44087

INTERNAL USE ONLY

Sender Information:				
Reviewer Information:	Approved	Denied	Date:	Time:
Date and Time of Communication to Pharmacy :				
REJCODE:				

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