

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

EIC Fentora Prior Authorization Request

Phone: 866-250-2005 Fax back to: 877-503-7231



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:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. Please indicate the patient's treatment diagnosis:

Breakthrough Cancer Pain

Other (please explain)

Q2. Please indicate all medications for this condition that have been tried and failed (with time frames):

Q3. Please provide any supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other additional clinical information to support an authorization request)

Physician Signature

Date