

**PRIOR AUTHORIZATION REQUEST FORM**

EOC ID:



**EIC Fentanyl Patch Step Therapy Exception 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 diagnosis below:

Q2. Does the patient have issues taking oral medications?

Yes      No

Q3. Is this initial therapy or continuing therapy?

Initial Therapy      Continuing Therapy

Q4. Please indicate below which agents have been tried and failed

- Oxycontin
- MS Contin/Morphine ER
- Opana ER
- Kadian
- Avinza
- Methadone

Q5. EIC has placed a quantity limit of 10 per 30 days on fentanyl patches. If the patient requires greater than 10 patches per 30 days please give rationale for a quantity limit exception:

Q6. For medical necessity reviews, you must provide a unique peer-reviewed journal article to support your request for off-label use. Please attach any medical information that may support approval

**Physician Signature**

**Date**