

## MEDICATION PRIOR AUTHORIZATION REQUEST FORM COORDINATED CARE, WASHINGTON

\*\*\* Do Not Use This Form for Biopharmaceutical Products \*\*\*

**FAX this completed form to (866) 399-0929**

**OR Mail requests to: Envolve Pharmacy Solutions PA Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720  
Call (866) 716-5099 to request a 72-hour supply of medication**

I. PROVIDER INFORMATION		II. MEMBER INFORMATION	
Prescriber name (print):		Member name:	
Office contact name:		Identification number:	
Group name:		Group number:	
Fax:		Date of Birth:	
Phone:		Medication allergies:	
III. DRUG INFORMATION (One drug request per form)			
Drug name and strength:	Dosage form:	Dosage Interval (sig)	Qty per Day:
Diagnosis relevant to <i>this</i> request:			
Expected length of therapy:			
Medication History for this Diagnosis			
<b>A.</b> Is member currently treated on this medication? <input type="checkbox"/> yes; How Long? _____ [go to item B] <input type="checkbox"/> no [skip items B & C; go to item D]			
<b>B.</b> Is this request for continuation of a previous approval? <input type="checkbox"/> yes [go to item C] <input type="checkbox"/> no [skip item C; go to item D]			
<b>C.</b> Has strength, dosage, or quantity required per day increased or decreased? <input type="checkbox"/> yes [go to item D] <input type="checkbox"/> no [skip item D; indicate rationale for continuation in Section IV and submit form]			
<b>D.</b> Please indicate previous treatment and outcomes below.			
Drug Name (include strength and dosage)	Dates of Therapy	Reason for Discontinuation	
1			
2			
3			
4			
NOTE: Confirmation of use will be made from member history on file; prior use of preferred drugs is a part of the exception criteria. <b>Coordinated Care Preferred Drug List (PDL)</b> is available on the <b>Coordinated Care</b> website at <a href="http://www.CoordinatedCareHealth.com">www.CoordinatedCareHealth.com</a> .			
IV. RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION (Required for all Prior Authorizations)			
Appropriate clinical information to support the request on the basis of medical necessity must be submitted.		Provider Signature:	Date:

Envolve Pharmacy Solutions will respond via fax or phone within 24 hours of receipt of the request. Requests for prior authorization must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)