MEDICATION PRIOR AUTHORIZATION REQUEST FORM

Western Sky Community Care, New Mexico

FAX this completed form to 866-399-0929

OR Mail requests to: Envolve Pharmacy Solutions PA Dept. / 5 River Park Place East, Suite 210 / Fresno, CA 93720

Call 844-792-2436 to request a 72-hour supply of medication.

Envolve Pharmacy Solutions will respond via fax or phone within 24 hours of receipt of all necessary information, except during weekends and holidays. For immediate response on weekends and holidays, NurseWise will answer your call.

I. Provider Information		II. Member Information
Prescriber name (print):		Member name:
Prescriber Specialty:		Identification number:
Fax:	Phone:	Date of Birth:
Office Contact Name:		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 ***this*** request:

Expected length of therapy:

Medication History for this Diagnosis

A. Is member currently treated on this medication?
☐ yes; How Long?_______________ [go to item B] ☐ no [skip items B & C; go to item D]

B. Is this request for continuation of a previous approval?
☐ yes [go to item C] ☐ no [skip item C; go to item D]

C. Has strength, dosage, or quantity required per day increased or decreased?
☐ yes [go to item D] ☐ no [skip item D; indicate rationale for continuation in Section IV and submit form]

D. 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. The **Western Sky Community Care Preferred Drug List (PDL)** is available on the **Western Sky Community Care** website at **www.westernskycommunitycare.com.**

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:

Requests for prior authorization (PA) must include member name, ID#, and drug name. **Incomplete forms will delay processing**. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)