

## MEDICATION PRIOR AUTHORIZATION REQUEST FORM Peach State Health Plan, Georgia

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



FAX this completed form to 1.866.399.0929

<u>OR</u> Mail requests to: Envolve Pharmacy Solutions PA Dept. | 5 River Park Place East, Suite 210 | Fresno, CA93720 Call 800-460-8988 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. For immediate response on weekends and holidays, Nurse Advice Line will answer your call.

I. Provider Information			II. Member Information	
Prescriber name (print):			Member name:	
Prescriber Specialty:			Identification number:	
Trescriber opecially.				
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 <i>this</i> 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]				
<b>B.</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 dosag	ge) 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 <b>Peach State Health Plan Preferred Drug List (PDL)</b> is available on the <b>Peach State Health Plan</b> website at <a href="https://www.pshp.com">www.pshp.com</a> .				
IV. Rationale for Request / Pertinent Clinical Information (Required for all Prior Authorizations)				
Appropriate clinical information to support the basis of medical necessity must be sub		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.)