

Actimmune-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

D.C. (N	B	
Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (i	f applicable):
*Please note that Envision will process th	e request as written, including drug	name, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical histor	ry or information for this patient that may following questions and sign.	support approval. Please answer the
	<u> </u>	
Q1. Is this request for initial or continuing t	herapy?	
☐ Initial therapy	☐ Continuing the	erapy
Q2. If the request is for CONTINUING T	HERAPY, please provide the start date	e (MM/YY):
Q3. Please indicate the patient's diagnosis	s for the requested medication: *	
☐ Chronic granulomatous disease		
☐ Malignant osteoporosis (severe)		
☐ Other		
Q4. If the patient's diagnosis is OTHER	places specify below:	
Q4. If the patient's diagnosis is Official	, please specify below.	
Prescriber Signature		Date



Actimmune-2 Medicare

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Rx 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: Prescriber Name:



Adempas-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
	<u> </u>	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	State Lic ID:
Group Number: Address:	Address:	State Lic ID.
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name	(if applicable):
*Please note that Envision will process the request as и		
, , , , , , , , , , , , , , , , , , ,	☐ Expedited/Urg	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that ma	ay support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing th	nerapy
Q2. For CONTINUING THERAPY, please provide the	start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the reques	ted medication:	
☐ Chronic thromboembolic pulmonary hypertension (CTEPH) (World Health	Organization group 4)
☐ Pulmonary arterial hypertension (PAH) (World Hea☐ Other	lth Organization group	1)
Q4. For a diagnosis of CTEPH, please select all that ap	oply:	
☐ Patient has persistent or recurrent disease after☐ Patient's disease is inoperable☐ None of the above	surgical treatment (e.	g. pulmonary endarterectomy)
Q5. For a diagnosis of PAH, was the diagnosis confirm	ed by right heart cathe	terization?
☐Yes	☐ No	
Q6. If the patient's diagnosis is OTHER, please specify	below:	
Q7. If the patient is FEMALE, is she enrolled in the ADEM	IPAS REMS program?	,



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Patient Name:	Prescriber Name:
☐ Yes ☐ No ☐ N/A - the patient is not female	
Q8. Is the patient 18 years of age or older?	
☐Yes	□No
Prescriber Signature	Date



ADHD-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
-		Di
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact: NPI:	State Lie ID:
Group Number: Address:	Address:	State Lic ID:
City, State ZIP:	City, State ZIP:	
•		f annlicable):
Primary Phone: Specialty/facility name (if applicable):		
*Please note that Envision will process the reque	<u>_</u>	•
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions / SIG:		
Birections / Gro.		
Please attach any pertinent medical history or info	ormation for this patient that may	v support approval. Please answer the
	wing questions and sign.	, capport approvant react another and
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	erapy
Q2. If the request is for CONTINUING THERAF	Y, please provide the start date	e (MM/YY):
Q3. Please indicate which medication is being req	uested:	
☐ Amphetamine-dextroamphetamine ER		
☐ Daytrana Patch		
☐ Dextroamphetamine ER		
☐ Dextroamphetamine IR		
☐ Methylphenidate		
☐ Vyvanse		
Q4. Please indicate the patient's diagnosis for the	requested medication:	
	requested medication.	
Attention deficit disorder (ADD)	ID)	
Attention Deficit Hyperactivity disorder (ADI	1D)	
□ Narcolepsy		
☐ Other		
Q5. For NARCOLEPSY, have sleep studies bed	en completed which support the	e diagnosis?
☐ Yes	□No	
		



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Patient Name:		Prescriber Name:
Q6. If the patient's diagnosis	is OTHER, please specify	below:
Q7. Please indicate the patient	's age below:	
☐ Under 3 years	☐ 3-5 years	6 years or older
Q8. Has the prescriber conside	red the benefits of use ver	sus the potential risks of serious cardiovascular events?
☐Yes		□No
Q9. Will the patient be using ar	MAOI concurrently with the	ne requested medication, or within the last 14 days?
☐ Yes		□No
Q10. Is the prescriber a psyddrugs?	chiatrist with experience pr	escribing both MAOI and amphetamine/dextroamphetamine
☐ Yes		□ No
Prescriber Si	gnature	Date



Alecensa-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Prescriber Name:		
Fax:	Phone:	
Office Contact:		
NPI:	State Lic ID:	
Address:		
City, State ZIP:		
Primary Phone: Specialty/facility name (if applicable):		
written, including drug	name, with no substitution.	
☐ Expedited/Urge	ent	
on for this patient that may	/ support approval. Please answer the	
uestions and sign.	,	
☐ Continuing the	erapy	
start date (MM/YY):		
sted medication: *		
fy below:		
(41.16) 6		
(ALK)- positive?		
	Office Contact: NPI: Address: City, State ZIP: Specialty/facility name (in written, including drug) Expedited/Urge Denoting the start date (MM/YY): Sted medication: * Other	



Alecensa-3 Medicare

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Patient Name:	Prescriber Name:
Prescriber Signature	Date



Alpha-1 Proteinase Inhibitor-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):
*Please note that Envision will process the reque	est as written, including drug	name, with no substitution.
	☐ Expedited/Urg	ent
Drug Name and Strength:		
Directions / CIC:		
Directions / SIG:		
Please attach any pertinent medical history or info	ormation for this patient that ma	y support approval. Please answer the
	wing questions and sign.	
Q1. Is this request for initial or continuing therapy?)	
		orony
☐ Initial therapy	☐ Continuing the	егару
Q2. If the request is for CONTINUING THERAF	Y, please provide the start date	e (MM/YY):
Q3. Please indicate the patient's diagnosis for the	requested medication:	
☐ Alpha-1-antitrypsin (AAT) deficiency	☐ Other	
Q4. If the patient's diagnosis is OTHER, please	specify below:	
Q5. Is the patient 18 years of age or older?		
☐ Yes	☐ No	
Q6. Please select all that apply for this patient:		
☐ The alpha1-proteinase inhibitor concentration	on is less than 11 micromoles r	ner liter
☐ The patient's FEV1 level is between 35% ar	·	
☐ The patient's FEV1 level is greater than 60%	•	
None of the above	p. Galotoa	
Q7. IF THE FEV1 IS GREATER THAN 60% PR		erienced a rapid decline in lung function
(i.e., reduction of FEV1 more than 120 mL/year) that warrants treatment?	



Alpha-1 Proteinase Inhibitor-1 Medicare

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Patient Name:	Prescriber Name:		
Yes	□ No		
Q8. Does the patient have IgA deficiency with antibodies against IgA?			
☐ Yes	□ No		
Prescriber Signature	 Date		



Alunbrig-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone: Specialty/facility name (if applicable):		
*Please note that Envision will process the request as	written, including drug	name, with no substitution.
	☐ Expedited/Urg	ent
Drug Name and Strength:		
Directions / SIG:		
Directions / Gig.		
Please attach any pertinent medical history or information		y support approval. Please answer the
following q	uestions and sign.	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	erapy
Q2. For CONTINUING THERAPY, please provide the	e start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the reque	sted medication:	
☐ Non-small cell lung cancer (NSCLC), metastatic	☐ Other	
Q4. For NSCLC, is the patient anaplastic lymphoma k	inase (ALK)-positive?	
☐ Yes	☐ No	
Q5. If the patient's diagnosis is OTHER, please specif	fy below:	
Q6. Has the patient experienced disease progression or	n (or is intolerant to) crizo	tinib (Xalkori)?
☐Yes	☐ No	
Q7. Is the patient 18 years of age or older?		
☐ Yes	□No	
Q8. Is the requested medication being prescribed by (or	in consultation with) an o	oncologist?



Alunbrig-3 Medicare

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□ No



Ambrisentan-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
	1	Di
Member/Subscriber Number: Date of Birth:	Fax: Office Contact:	Phone:
	NPI:	State Lic ID:
Group Number: Address:	Address:	State Lic ID.
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if a	applicable):
*Please note that Envision will process the request as v		
· ,	☐ Expedited/Urger	
Drug Name and Strength:		
21		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may lestions and sign.	support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing there	ару
Q2. For CONTINUING THERAPY, please specify the s	start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the reques	ted medication:	
☐ Pulmonary arterial hypertension (PAH), WHO Grou	p I 🔲 Other	
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. For PAH, has the diagnosis been confirmed by right unable to undergo a right heart catheterization (e.g., patie		oppler echocardiogram if patient is
☐Yes	☐ No	
Q6. Is the patient pregnant?		
☐ Yes	☐ No	
Q7. For FEMALE PATIENTS OF CHILD-BEARING POTE	ENTIAL, please select all	that apply:
☐ Pregnancy has been excluded prior to the start of t☐ The patient has been educated about the potential pregnancy	herapy	



Ambrisentan-2 Medicare

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Rx 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:	Prescriber Name:
 ☐ Women of childbearing potential will be using an IUD or two appropriate contraceptive methods ☐ None of the above ☐ N/A - The patient is not a female of child-bearing potential 	
Prescriber Signature	 Date



Ampyra-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if	applicable):
*Please note that Envision will process the	request as written, including drug n	name, with no substitution.
	☐ Expedited/Urger	nt
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history	or information for this patient that may following questions and sign.	support approval. Please answer the
Q1. Is this request for initial or continuing the	erapy?	
☐ Initial therapy	☐ Continuing ther	ару
Q2. For CONTINUING THERAPY, please	e specify the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for	or the requested medication: *	
☐ Multiple sclerosis (MS)	☐ Other	
Q4. If the patient's diagnosis is OTHER, p	lease specify below:	
Q5. Has patient demonstrated sustained wa assistance) prior to starting Ampyra?	lking impairment, but with the ability to	walk 25 feet (with or without
☐ Yes	□No	
Q6. Is the patient 18 years of age or older?		
☐ Yes	☐ No	
Q7. Is the requested medication being preso	cribed by (or in consultation with) a neu	ırologist?
☐ Yes	☐ No	
Q8. Does the patient have any of the following (please select all that apply)?		



Prescriber Signature

EOC ID:

Ampyra-2 Medicare

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Date



Analeptics-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if	applicable):
*Please note that Envision will process the request as v	vritten, including drug r	name, with no substitution.
	☐ Expedited/Urger	nt
Drug Name and Strength:		
Directions / SIG:		
Disease attack any neutinent medical history or information	n fau thia nationt that may	cumpart approval Places approve the
Please attach any pertinent medical history or information following qu	n for this patient that may lestions and sign.	support approval. Flease allswer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing ther	ару
Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):		
Q2. If the request is for CONTINUING THERAPT, plea	ase provide the start date	(IVIIVI/ T T).
Q3. Please indicate which medication this request is for:		
☐ Armodafinil	☐ Modafinil	
Q4. For MODAFINIL, is the patient 17 years of age or	older?	
_		
Yes	∐ No	
Q5. Please indicate the patient's diagnosis for the reques	sted medication: *	
Excessive sleepiness associate with narcolepsy		
Excessive sleepiness associated with shift work sle	eep disorder (SWSD)	
Excessive sleepiness associated with obstructive s	• • • • • • • • • • • • • • • • • • • •	ndrome (OSA/HS)
Other		,
OS For NAPCOLEDSV has the nations tried and faile	d (or had a contraindigation	on or intolorance to) at least one other
Q6. For NARCOLEPSY, has the patient tried and failed central nervous system stimulant (such as methylphen	•	•
Yes	□ No	
Q7. For SWSD, please select all that apply to this patie	ent:	



Analeptics-3 Medicare

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Patient Name:	Prescriber Name:
☐ The patient experiences excessive sleepiness frequently (5 times or more per month) ☐ The patient experiences excessive sleepiness while working ☐ None of the above	
Q8. If the patient's diagnosis is OTHER, please specify	y below:
Prescriber Signature	Date



Arcalyst-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):
Please note that Envision will process the request as	written, including drug	name, with no substitution.
	☐ Expedited/Urg	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informatio following qu	on for this patient that ma uestions and sign.	y support approval. Please answer the
	-	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	erapy
Q2. For CONTINUING THERAPY, please specify the start date (MM/YY):		
Q3. For CONTINUING THERAPY, has the patient's co	ondition improved or stat	pilized?
☐Yes	☐ No	
Q4. Please indicate the patient's diagnosis for the reques	sted medication:	
	☐ Other	
☐ Cryopyrin-associated periodic syndrome (CAPS)		
Q5. If the patient's diagnosis is OTHER, please specif	y below:	
Q6. Is the patient 12 years of age or older?		
☐ Yes	☐ No	
Q7. Does the patient have any of the following (please se	elect all that apply)?	
☐ Active infection		
☐ Chronic infection		
☐ Concurrent therapy with other biologics		
☐ None of the above		



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EOC ID:

Phone: 800-361-4542

Arcalyst-2 Medicare

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Prescriber Signature

Date



Arikayce-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

	I	
Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone: Specialty/facility name (if applicable):		
*Please note that Envision will process the request as v	vritten, including drug i	name, with no substitution.
	☐ Expedited/Urge	nt
Drug Name and Strength:		
Directions / SIG:		
Disease attack any neutinent medical history or information	n for this notions that may	aumost approval Places approve the
Please attach any pertinent medical history or informatio following qu	n for this patient that may lestions and sign.	support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	rapy
Q2. For CONTINUING THERAPY, please provide the	start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the reques	sted medication:	
☐ Pulmonary Mycobacterium avium complex (MAC)	Other	
infection	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify	helow.	
a ii ii ale padelike diaglioole le e ii le ii, piedee epesii,	, 55.511.	
05 MENA 11 11 11 11 11 11 11		
Q5. Will Arikayce be used in combination with other antib	_	
☐ Yes	☐ No	
Q6. Has the patient been treated for 6 consecutive month	ns with multidrug backgro	ound regimen therapy?
Yes	□ No	
Q7. Has the patient achieved negative sputum cultures	s from prior treatment?	
Yes	☐ No	
_		
Q8. Is the patient 18 years of age or older?		



Arikayce-1 Medicare

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Patient Name:	Prescriber Name:
☐ Yes	□No
Q9. Is the requested medication being prescribed by (or in consultation with) an infectious disease specialist or pulmonologist?	
☐ Yes	□ No
Prescriber Signature	Date



Atypical Antipsychotics-12 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (i	f applicable):
*Please note that Envision will process the request as v	vritten, including drug	name, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following gu	n for this patient that may restions and sign.	y support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	erany
Q2. For CONTINUING THERAPY, please provide the	start date (MM/YY):	
Q3. Please indicate which medication this request is for:		
☐ Fanapt ☐ Saphris		☐ Vraylar
Q4. Please indicate the patient's diagnosis for the reques	ted medication:	
☐ Bipolar I disorder (manic or mixed episodes)		
☐ Dementia-related psychosis only		
Schizophrenia		
☐ Other		
Q5. If the patient's diagnosis is OTHER, please specify	/ below:	
gormano panomo anagnosio io o mient, prouso spesin,		
OO Disease in Franks II. II. II.		
Q6. Please indicate the patient's age below:		
Under 10 years of age		
10-17 years of age		
☐ 18-64 years of age		
☐ 65 years of age or older		



Atypical Antipsychotics-12 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:	
Q7. Has the patient tried and failed (or has a documented intolerance or contraindication to) any of the following (please select all that apply)?		
☐ Aripiprazole ☐ Olanzapine		
Risperidone		
Quetiapine		
☐ Ziprasidone ☐ None of the above		
Prescriber Signature	Date	



Auryxia-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):
*Please note that Envision will process the reques	st as written, including drug	name, with no substitution.
☐ Expedited/Urgent		
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or info follow	rmation for this patient that ma ving questions and sign.	y support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	erapy
Q2. For CONTINUING THERAPY, please provide	the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the r	requested medication:	
☐ Hyperphosphatemia	·	
☐ Iron deficiency anemia		
☐ Other		
Q4. Does the patient have chronic kidney disease	(CKD)3	
Yes	☐ No	
Q5. Is the patient on dialysis?		
☐ Yes	□No	
		
Q6. Is the patient 18 years of age or older?		
☐ Yes	☐ No	
I		



Prescriber Signature

EOC ID:

Auryxia-1 Medicare

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Date



Austedo-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	i none.
Group Number:	NPI:	State Lic ID:
Address:	Address:	2.0.02
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if	fapplicable):
*Please note that Envision will process the request as	written, including drug	name, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following q	on for this patient that may	support approval. Please answer the
	<u> </u>	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	rapy
Q2. If the request is for CONTINUING THERAPY, ple	ase provide the start date	e (MM/YY):
Q3. Please indicate the patient's diagnosis for the reque	sted medication:	
☐ Chorea associated with Huntington's Disease		
☐ Tardive Dyskinesia - medication-induced		
☐ Other		
Q4. For HUNTINGTON'S DISEASE, does the prescril days?	ber attest that patient has	NOT taken an MAOI in the past 14
Yes	□No	
Q5. For TARDIVE DYSKINESIA, does the patient have	ve a history of using a dop	pamine receptor antagonist?
☐ Yes	□No	
Q6. If the patient's diagnosis is OTHER, please speci-	fy below:	
Q7. Is the patient 18 years of age or older?		
	□No	
Yes	□ No	



Austedo-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
Q8. Is the requested medication being prescribed by (or in consultation with) a psychiatrist or neurologist?	
☐ Yes	□ No
Q9. Does the patient have any of the following (please set Any degree of hepatic impairment or hepatic disease Active suicidal ideation Untreated or inadequately treated depression None of the above	
Prescriber Signature	Date



Balversa-12 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (i	f applicable):
*Please note that Envision will process the request as w	ritten, including drug	name, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	i for this patient that may estions and sign.	y support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	erapy
.,	-	
Q2. For CONTINUING THERAPY, please provide the s	start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the request	ted medication:	
☐ Urothelial carcinoma, locally advanced or metastation	c ☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Is the patient 18 years of age or older?		
∏Yes	☐ No	
Q6. Is the requested medication prescribed by (or in cons	ultation with) an oncolog	gist or urologist?
☐ Yes	☐ No	
Q7. Do any of the following apply to this patient (please so	elect all that apply)?	
The patient has susceptible FGFR3 or FGFR2 general		
		tinum-containing chemotherapy
☐ The patient has progressed during or following at least one line of prior platinum-containing chemotherapy, including within 12 months of neoadjuvant or adjuvant platinum-containing chemotherapy		
None of the above		



Prescriber Signature

EOC ID:

Balversa-12 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:	

Date



Bosentan-6 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	. Herie.
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if app	plicable):
*Please note that Envision will process the request as	written, including drug nan	ne, with no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.		
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therap	у
Q2. If the request is for CONTINUING THERAPY, ple	ase provide the start date (M	IM/YY):
Q3. Please indicate the patient's diagnosis for the reque	sted medication:	
☐ Pulmonary arterial hypertension (PAH)	Other	
Q4. If the patient's diagnosis is OTHER, please specif	y below:	
Q5. Has the diagnosis of PAH been confirmed by either Right heart catheterization Doppler echocardiogram (if patient is unable to unetc.]) None of the above	Ç	zation [e.g., patient is frail, elderly,
Q6. Does the patient have World Health Organization (W Functional Class II-IV symptoms?	/HO) Group 1 and New York	Heart Association (NYHA)
☐ Yes	□No	



Bosentan-6 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
Q7. FOR FEMALE PATIENTS OF CHILD-BEARING POT patient will use two forms of reliable contraception during	FENTIAL, has pregnancy been excluded prior to therapy and therapy?
Yes	
∐ No	
□ N/A - patient is not a female of child-bearing potential □ N/A - patient is not a female of child-bearing potential □ N/A - patient is not a female of child-bearing potential □ N/A - patient is not a female of child-bearing potential □ N/A - patient is not a female of child-bearing potential □ N/A - patient is not a female of child-bearing potential □ N/A - patient is not a female of child-bearing potential □ N/A - patient is not a female of child-bearing potential □ N/A - patient is not a female of child-bearing potential □ N/A - patient is not a female of child-bearing potential □ N/A - patient is not a female of child-bearing potential □ N/A - patient is not a female of child-bearing potential □ N/A - patient is not a female of child-bearing potential □ N/A - patient is not a female of child-bearing potential □ N/A - patient is not a female of child-bearing potential □ N/A - patient is not a female of child-bearing potential □ N/A - patient is not a female of child-bearing potential □ N/A - patient is not a female of child-bearing potential □ N/A - patient is not a female of child-bearing potential □ N/A - patient is not a female of child-bearing potential □ N/A - patient is not a female of child-bearing potential □ N/A - patient is not a female of child-bearing potential □ N/A - patient is not a female of child-bearing potential □ N/A - patient is not a female of child-bearing potential □ N/A - patient is not a female of child-bearing potential □ N/A - patient is not a female of child-bearing potential □ N/A - patient is not a female of child-bearing potential □ N/A - patient is not a female child-bearing potential □ N/A - patient is not a female child-bearin	
Q8. Does the patient have aminotransferase elevations a injury or bilirubin at least 2 times the upper limit of normal	
Yes	□ No
Q9. Will the patient be receiving concomitant cyclosporine	e A or glyburide therapy?
Yes	□ No
Prescriber Signature	 Date



Bosulif-4 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if ap	plicable):
*Please note that Envision will process the request as v	vritten, including drug nar	me, with no substitution.
☐ Expedited/Urgent		
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information	n for this patient that may su	pport approval. Please answer the
	estions and sign.	pport approximation and amount and
O1 Is this request for initial or continuing therapy?		
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therap	У
Q2. If the request is for CONTINUING THERAPY, plea	se provide the start date (M	IM/YY):
Q3. Please indicate the patient's diagnosis for the reques	ted medication:	
☐ Philadelphia chromosome-positive (Ph+) chronic mye		chronic accolorated or blact phase)
Philadelphia chromosome-positive (Ph+) chronic mye	` , ,	
Other	logerious icuneriila (OML) (newly diagnosed offerine phase)
Q4. For Ph+ CML IN THE CHRONIC, ACCELERATED		
or inadequate response to prior therapy with one of the apply)?	iollowing tyrosine kinase ii	inibitors (TKI) (please select all that
☐ Gleevec (imatinib) ☐ Sprycel (dasatinib)		
☐ Tasigna (nilotinib) ☐ None of the above		
☐ Notile of the above		
Q5. If the patient has NOT tried any of the medicati		
medications cannot be used (i.e. contraindication, h	istory of adverse event, dis	ease is resistant or intolerant,
etc)?		



Bosulif-4 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
Q6. If the patient's diagnosis is OTHER, please specify	below:
Q7. Is the patient at least 18 years of age or older?	
Yes	□ No
Prescriber Signature	 Date



Braftovi-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	
*Please note that Envision will process the request as	written, including drug	name, with no substitution.
	☐ Expedited/Urge	nt
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information	on for this natient that may	support approval. Please answer the
	uestions and sign.	Support approval. I lease allower the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	rapy
Q2. For CONTINUING THERAPY, please provide the sta	art date (MM/YY):	
, , , , , , , , , , , , , , , , , , , ,	(
Q3. Please indicate the patient's diagnosis for the reques	sted medication:	
Melanoma (unresectable or metastatic)	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify t	pelow:	
Q5. Does the patient have BRAF V600E or V600K mutat	tion as detected by an FD	A-approved test?
☐ Yes	□ No	• •
Q6. Will Braftovi be used in combination with Mektovi (bi	nimetinib)?	
☐ Yes	☐ No	
Q7. Is the requested medication being prescribed by (or	in consultation with) an a	neelegist?
		ricologist?
Yes	☐ No	
Q8. Is the patient 18 years of age or older?		



Prescriber Signature

EOC ID:

Braftovi-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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: Prescriber Name:** ☐ Yes ☐ No

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Date



Cablivi-13 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

	1	
Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if a	applicable):
*Please note that Envision will process the request as	written, including drug n	ame, with no substitution.
	☐ Expedited/Urgen	t
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information	on for this patient that may suestions and sign.	support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy ☐ Continuing therapy		
		ару
Q2. For CONTINUING THERAPY, please provide the	start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the reques	sted medication:	
☐ Thrombotic thrombocytopenic purpura, acquired		
(aTTP)	☐ Other	
· ·		
Q4. If the patient's diagnosis is OTHER, please specif	y below:	
Q5. Is the patient 18 years of age and older?		
☐ Yes	□No	
Q6. Will the requested medication be used in combination	n with plasma exchange a	nd immunosuppression therapy?
☐ Yes	☐ No	
Q7. Please indicate the Prescriber's specialty:		
☐ Hematologist ☐ Oncologis	Ţ	☐ None of the above



Cablivi-13 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Na	me:
Prescriber Signature		Date



Cabometyx-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (i	f applicable):
*Please note that Envision will process the red	quest as written, including drug	name, with no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
D: 1: (010		
Directions / SIG:		
Please attach any pertinent medical history or		y support approval. Please answer the
fc	ollowing questions and sign.	
Q1. Is this request for initial or continuing thera	py?	
☐ Initial therapy	☐ Continuing the	erapy
Q2. If the request is for CONTINUING THER	RAPY, please provide the start date	e (MM/YY):
·		
Q3. Please indicate the patient's diagnosis for t	the requested medication:	
☐ Renal cell carcinoma (advanced)	☐ Other	
Q4. If the patient's diagnosis is OTHER, plea	ase specify below:	
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
Q5. Is the patient 18 years of age or older?		
☐Yes	□No	
Prescriber Signature		Date



Cabometyx-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
Prescriber Signature	Date



Calquence-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name ((if applicable):
*Please note that Envision will process the request a	as written, including drug	name, with no substitution.
	☐ Expedited/Urg	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or inform following	ation for this patient that ma g questions and sign.	y support approval. Please answer the
	<u></u>	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing th	erany
		Стару
Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):		
Q3. Please indicate the patient's diagnosis for the req	uested medication:	
☐ Mantle cell lymphoma (MCL) ☐ Other		
Q4. If the patient's diagnosis is OTHER, please spe	ecify below:	
Q5. Has the patient received at least one (1) prior the	rapy for MCL?	
☐ Yes	□No	
Q6. Is Calquence being prescribed by (or in consultat	ion with) an oncologist?	
☐ Yes	☐ No	
Q7. Is the patient 18 years of age or older?		
☐ Yes	☐ No	



Calquence-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:	
Prescriber Signature	 Date	



Cayston-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name	e (if applicable):
*Please note that Envision will process the request as w	vritten, including dru	ig name, with no substitution.
	☐ Expedited/U	rgent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information	s for this nations that n	any number approval. Plance appwer the
	estions and sign.	nay support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing t	therapy
Q2. For CONTINUING THERAPY, please indicate the start date (MM/YY):		
Q3. For CONTINUING THERAPY, please select all that	it apply:	
☐ The patient is benefitting from treatment (for example)	ample, improvement i	n lung function [FEV1], decreased
number of pulmonary exacerbations)		
☐ There is clinical reason to continue therapy (such as symptomatic improvement or pulmonary function tests		
have not deteriorated more than 10% from baseline) None of the above		
_		
Q4. Please indicate that patient's diagnosis for the reques	sted medication:	
☐ Cystic fibrosis (CF) ☐ Other		
Q5. If the patient's diagnosis is OTHER, please specify below:		
do: Il allo padolico diagnosio io o l'ilei i, piodos oposily	20.0	
		tin so
Q6. Has the diagnosis been confirmed by appropriate dia		ung r
☐ Yes ☐ No		
Q7. Does the patient have evidence of P. aeruginosa in the lungs as confirmed by cultures of the airways?		



Cayston-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:	
☐Yes	□No	
Q8. Is the patient 7 years of age or older?		
Yes	□No	
		_
Prescriber Signature	 Date	



Copiktra-4 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if app	olicable):
*Please note that Envision will process the request as	written, including drug nan	ne, with no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information	on for this natient that may su	nnort approval. Please answer the
	uestions and sign.	oport approval. I lease answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy ☐ Continuing therapy		
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):		
	(
Q3. Please indicate the patient's diagnosis for the reques	etad madication:	
Chronic lymphocytic leukemia/small lymphocytic lym	pnoma (CLL/SLL), relapsed	or retractory
☐ Follicular lymphoma, relapsed or refractory ☐ Other		
Other		
Q4. If the patient's diagnosis is OTHER, please specif	y below:	
Q5. Has the patient been treated with at least 2 prior the	rapies?	
☐ Yes	☐ No	
Q6. Is the requested medication being prescribed by (or	in consultation with) an onco	logist or hematologist?
☐ Yes	☐ No	
Q7. Is the patient 18 years of age or older?		
☐ Yes	□No	
	□	



Copiktra-4 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:	
Prescriber Signature	Date	



Corlanor-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if a	applicable):
*Please note that Envision will process th	ne request as written, including drug n	ame, with no substitution.
	☐ Expedited/Urgen	t
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical histo	ry or information for this patient that may s following questions and sign.	support approval. Please answer the
Q1. Is this request for initial or continuing	therapy?	
☐ Initial therapy	☐ Continuing there	ару
Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):		
Q3. Please indicate the patient's diagnosis	s for the requested medication:	
☐ Chronic heart failure (stable, sympton	omatic)	
Stable, symptomatic heart failure due to dilated cardiomyopathy in patients who are in sinus rhythm with an		
elevated heart rate		
Other		
Q4. If the patient's diagnosis is OTHER	, please specify below:	
Q5. Is the patient's left ventricular ejection	fraction (LVEF) 35% or less?	
☐Yes	□No	
Q6. Is the patient in sinus rhythm with rest	ting heart rate of 70 beats per minute or r	more?
☐Yes	□No	
Q7. Is the patient on maximally tolerated of	loses of beta blockers OR has a contrain	dication to beta blocker use?
☐ Yes		



Corlanor-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
Q8. Does the patient have any of the following (please select all that apply)?	
☐ Decompensated acute heart failure	
☐ Hypotension (i.e. blood pressure less than 90/50 mmHg)	
☐ Sick sinus syndrome, sinoatrial block, or 3rd degree AV block (unless a functioning demand pacemaker is	
present)	
☐ Bradycardia (i.e. resting heart rate is less than 60 beats per minute prior to treatment)	
☐ None of the above	
Prescriber Signature	Date



Cosentyx-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Nam	e:
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility	name (if applicable):
*Please note that Envision will	process the request as written, includin	g drug name, with no substitution.
	☐ Exped	ited/Urgent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent mo	edical history or information for this patient following questions and sign	that may support approval. Please answer the
Q1. Is this request for initial or	continuing therapy?	
☐ Initial therapy	☐ Contin	uing therapy
Q2. For CONTINUING THEF	RAPY, please provide the start date (MM/Y	Y):
Q3. For CONTINUING THEA	ARPY, is there documentation that the pati	ent has had a positive clinical response to
☐ Yes	□ No	
Q4. Please indicate the patient	's diagnosis for the requested medication:	
☐ Ankylosing spondylitis (a	active)	
☐ Plaque psoriasis (moder		
☐ Psoriatic arthritis (active)	,	
☐ Other		
Q5. If the patient's diagnosis	s is OTHER, please specify below:	
Q6. Has the patient tried and fathat apply)?	ailed (or has a contraindication or intolerand	ce) to any of the following (please select all
☐ Enbrel	☐ Humira	☐ None of the above



Cosentyx-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:		Prescriber Na	ame:
·	as Enbrel, Humira, Cimzia	-	llowing (please select all that apply)?
Q8. For PSORIATIC ARTHRITI phosphodiesterase 4 (PDE4) in		IS, will the pat	tient be using Cosentyx in combination with a
☐ Yes	□ No		
Q9. Please indicate the prescrib	per's specialty below:		
☐ Dermatologist	☐ Rheumatol	ogist	☐ None of the above
Prescriber Sic	nature		Date



Cotellic-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):
*Please note that Envision will process the request as v	vritten, including drug name, wit	th no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may support a lestions and sign.	pproval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please indicate the start date (MM/YY):		
Q3. Please indicate the patient's diagnosis for the reques	ted medication:	
☐ Melanoma (unresectable or metastatic)	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify below:		
Q5. Does the patient have BRAF V600E or V600K mutati	ion?	
·		
Yes	□ No	
Q6. Will the requested medication be used in combination	n with vemurafenib (Zelboraf)?	
☐ Yes	□ No	



Cotellic-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:	
Prescriber Signature	Date	



Cystaran-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone: Specialty/facility name (if applicable):		
*Please note that Envision will process the request as	written, including drug	name, with no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
nections / Sig.		
Please attach any pertinent medical history or information	on for this patient that ma	y support approval. Please answer the
	uestions and sign.	
Q1. Is this request for initial or continuing therapy?		
Q1. Is this request for initial or continuing therapy?	☐ Continuing th	erapy
☐ Initial therapy	☐ Continuing th	
☐ Initial therapy Q2. If the request is for CONTINUING THERAPY, ple	ase provide the start dat	
☐ Initial therapy Q2. If the request is for CONTINUING THERAPY, ple Q3. Please indicate the patient's diagnosis for the reque	ease provide the start dates	
☐ Initial therapy Q2. If the request is for CONTINUING THERAPY, ple	ase provide the start dat	
☐ Initial therapy Q2. If the request is for CONTINUING THERAPY, ple Q3. Please indicate the patient's diagnosis for the reque ☐ Cystinosis	ease provide the start datasets as a provide the start datasets. Sted medication:	
☐ Initial therapy Q2. If the request is for CONTINUING THERAPY, ple Q3. Please indicate the patient's diagnosis for the reque	ease provide the start datasets as a provide the start datasets. Sted medication:	
☐ Initial therapy Q2. If the request is for CONTINUING THERAPY, ple Q3. Please indicate the patient's diagnosis for the reque ☐ Cystinosis Q4. If the patient's diagnosis is OTHER, please specifications.	ease provide the start dates steed medication: Other fy below:	
☐ Initial therapy Q2. If the request is for CONTINUING THERAPY, ple Q3. Please indicate the patient's diagnosis for the reque ☐ Cystinosis	ease provide the start dates steed medication: Other fy below:	



Cystaran-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
Prescriber Signature	Date



Daurismo-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone: Specialty/facility name (if applicable):		if applicable):
*Please note that Envision will process the request a	as written, including drug	name, with no substitution.
	☐ Expedited/Urg	ent
Drug Name and Strength:		
Directions / SIG:		
Sirections / Grd.		
Please attach any pertinent medical history or information	ation for this patient that ma	y support approval. Please answer the
following	g questions and sign.	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	erapy
Q2. For CONTINUING THERAPY, please provide	the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the req	uested medication:	
☐ Acute myeloid leukemia (newly diagnosed) ☐ Other		
Q4. If the patient's diagnosis is OTHER, please spe	ecify below:	
Q5. Does the patient have comorbidities that preclude	e the use of intensive induct	ion chemotherapy?
☐ Yes	☐ No	
Q6. Will Daurismo be used in combination with low-do	ose cytarabine?	
☐Yes	☐ No	
Q7. Is the patient 75 years of age or older?		
☐ Yes	☐ No	
Q8. Is the medication being prescribed by (or in const	ultation with) an oncologist	or hematologist?



Daurismo-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
☐ Yes	□ No
Prescriber Signatur	e Date



Diclofenac Topical-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (i	f applicable):
*Please note that Envision will process the	request as written, including drug	name, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history	or information for this patient that may following questions and sign.	/ support approval. Please answer the
Q1. Is this request for initial or continuing th	nerany?	
☐ Initial therapy	Continuing the	erapy
Q2. For CONTINUING THERAPY, pleas	e indicate the start date (MM/YY).	
00 51		
Q3. Please indicate the patient's diagnosis	for the requested medication:	
☐ Actinic keratosis	☐ Other	
Q4. If the patient's diagnosis is OTHER,	please specify below:	
Prescriber Signature		Date



Diclofenac Topical-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:

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Dronabinol-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if	applicable):
*Please note that Envision will process the request as written, including drug name, with no substitution.		
	☐ Expedited/Urge	nt
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history	or information for this patient that may following questions and sign.	support approval. Please answer the
Q1. Is this request for initial or continuing the	erapy?	
☐ Initial therapy ☐ Continuing therapy		
Q2. For CONTINUING THERAPY, please	specify the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for	or the requested medication: *	
☐ Anorexia associated with weight loss in a	a patient with AIDS	
☐ Nausea and vomiting (N/V) associated w☐ Other	•	
Q4. FOR ANOREXIA: Has the patient had weight OR a body mass index (BMI) less other than HIV that may cause weight loss	than 20kg/m2 in the absence of a con	
☐ Yes	□No	
Q5. FOR ANOREXIA: Has the patient faile	ed to respond to a 30-day trial of meg	estrol (Megace)?
☐ Yes	□No	
Q6. IF CONTINUING THERAPY FOR AN maintaining or increasing their initial weight	·	sitive response to therapy by
Yes	□No	



Dronabinol-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:	
Q7. FOR N/V: Is the patient currently receiving a chem	notherapy or radiation regimen?	
☐ Yes	□No	
Q8. FOR N/V: Is oral drug being used as a full therapeutic replacement for an intravenous anti-emetic drug as part of a cancer chemotherapeutic regimen administered within 48 hours of chemotherapy?		
☐ Yes	□No	
Q9. FOR N/V: Has the patient had a full trial and failure ondansetron?	e through at least one cycle of chemotherapy with IV	
☐ Yes	□No	
Q10. FOR N/V: Has the patient tried and failed at least promethazine, prochlorperazine, meclizine, trimethobe	t one of the following oral anti-emetic agents: metoclopramide, nzamide, or oral 5-HT3 receptor antagonists?	
☐ Yes	□No	
Q11. IF CONTINUING THERAPY FOR N/V: Has the p incidence of emesis and/or nausea?	patient shown a positive response to therapy by reduced	
☐Yes	□No	
Q12. If the patient's diagnosis is OTHER, please speci	fy below:	
Prescriber Signature	Date	



Enbrel-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if appl	icable):
*Please note that Envision will process the request as v	vritten, including drug nam	e, with no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information	n for this nationt that may sun	nort annroyal Plaasa answer the
	restions and sign.	port approval. Flease allswer tile
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the	start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the reques	ted medication:	
☐ Ankylosing spondylitis		
☐ Plaque psoriasis (moderate to severe)		
Polyarticular juvenile idiopathic arthritis (moderate to	severe)	
☐ Psoriatic arthritis		
☐ Rheumatoid arthritis (moderate to severe)		
☐ Other		
Q4. If the patient's diagnosis is OTHER, please specify	helow:	
Q4. If the patient's diagnosis is Official, please specify	bolow.	
Q5. Do any of the following apply to this patient (please s	,	
☐ The patient has an active serious infection (including	•	
The patient will be using Enbrel with another biolog	,	,
☐ The patient will be using Enbrel with potent immun	osuppressant (such as azath	ioprine or cyclosporine)
☐ None of the above		



Enbrel-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
Q6. Has the patient tried and failed (or has a contraindica select all that apply)?	ation or intolerance to) one or more of the following (please
☐ Methotrexate (MTX)	
☐ Non-biologic disease modifying anti-rheumatic drug	gs (DMARDs) for at least 3 consecutive months
☐ Non-steroidal anti-inflammatory drugs (NSAIDs)	
Conventional therapy with phototherapy (including retinoids [RePUVA]) for at least one continuous month	but not limited to Ultraviolet A with a psoralen [PUVA] and/or
☐ Conventional therapy with oral systemic treatments for at least 3 consecutive months	s (such as methotrexate, cyclosporine, acitretin, sulfasalazine)
☐ None of the above	
Q7. For PLAQUE PSORIASIS, does the patient's disease crucial body areas such as the hands, feet, face, or genit	e affect more than 5% of the body surface area (BSA) or affect als?
☐ Yes	□ No
Q8. Please indicate the patient's age below:	
☐ Under 2 years	
2-3 years	
☐ 4-17 years	
☐ 18 years or older	
Prescriher Signature	Date



Endari-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):
*Please note that Envision will process the requ	est as written, including drug	name, with no substitution.
	☐ Expedited/Urg	ent
Drug Name and Strength:		
Directions / SIG:		
Directions / GIG.		
Please attach any pertinent medical history or inf	ormation for this patient that ma	y support approval. Please answer the
	3 1	
Q1. Is this request for initial or continuing therapy	?	
☐ Initial therapy	☐ Continuing the	erapy
Q2. If the request is for CONTINUING THERA	PY, please provide the start dat	e (MM/YY):
Q3. Please indicate the patient's diagnosis for the	requested medication:	
☐ Sickle cell disease (acute)	☐ Other	
Q4. If the patient's diagnosis is OTHER, please	e specify below:	
Q5. Has the patient tried and failed (or has an inte	olerance or contraindication to)	hydroxyurea?
☐ Yes	☐ No	
Q6. Is the patient 5 years of age or older?		
☐ Yes	□No	



Endari-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
Prescriber Signature	Date



Entresto-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if	f applicable):
*Please note that Envision will process the request as v	vritten, including drug	name, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
D: 11 / 100		
Directions / SIG:		
Please attach any pertinent medical history or information	n for this patient that may	support approval. Please answer the
	estions and sign.	, cappert approvair i loude allerter and
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	erapy
Q2. For CONTINUING THERAPY, please provide the	start date (MM/YY):	
	,	
Q3. Please indicate the patient's diagnosis for the reques	ted medication:	
☐ Heart failure	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Please select the patient's New York Heart Association	on (NYHA) Class of hea	rt failure:
NYHA Class I	, ,	
NYHA Class II		
NYHA Class III		
☐ NYHA Class IV		
Q6. Does the patient have any of the following EXCLUSION	ONS (please select all th	nat anniv)?
		• • • •
Patient has history of angioedema related to previo		
Patient will be using Entresto concomitantly, or with		
☐ Entresto will be used concomitantly with aliskiren (☐ None of the above	rekturna) in a diabetic p	alleni
☐ Notice of the above		



Entresto-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:	
Q7. Is the patient at least 18 years of age or older?		
☐ Yes	□ No	
Prescriber Signature	Date	



Epidiolex-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
 Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if application)	able):
*Please note that Envision will process the request as v	vritten, including drug name,	with no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:	, •	
Discretions (OIO)		
Directions / SIG:		
Please attach any pertinent medical history or information	n for this patient that may suppo	ort approval. Please answer the
	estions and sign.	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the	start date (MM/YY):	
	,	
Q3. Please indicate the patient's diagnosis for the reques	ted medication:	
Severe myoclonic epilepsy in infancy		
Lennox-Gestaut syndrome (LGS)		
☐ Other		
Q4. Is the patient 2 years of age or older?		
☐ Yes	□No	
Q5. If the patient's diagnosis is OTHER, please specify	/ below:	
Q6. Is the requested medication being prescribed by (or i	n consultation with) a neurolog	ist?
☐ Yes	□No	



Epidiolex-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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: Prescriber Name:** Prescriber Signature Date



Erleada-12 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (i	f applicable):
*Please note that Envision will process the request as	written, including drug	name, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following q	on for this patient that may uestions and sign.	y support approval. Please answer the
	accircus and orgin	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	егару
Q2. For CONTINUING THERAPY, please provide the	start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the reque	sted medication:	
☐ Non-metastatic castration-resistant prostate cancer		
☐ Metastatic, castration-sensitive prostate cancer		
☐ Other		
Q4. If the patient's diagnosis is OTHER, please specif	fy below:	
Q5. Is the patient 18 years of age or older?		
☐ Yes	□No	
Q6. Is the requested medication being prescribed by (or	in consultation with) an o	ncologist or urologist?
	ŕ	incologist of diologist:
Yes	□ No	
Q7. Is the patient's partner pregnant?		
☐ Yes ☐ No		□ N/A



Erleada-12 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
Prescriber Signature	 Date



ESA-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if application)	able):
*Please note that Envision will process the request as v	vritten, including drug name,	with no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informatio	n for this nationt that may suppo	art approval. Places answer the
	restions and sign.	ort approval. Flease answer tile
Q1. Is this request for initial therapy or continuing therapy	/? *	
☐ Initial therapy	☐ Continuing therapy	
O2 For CONTINUING THERADY places aposity the	etert data (MMM/VV):	
Q2. For CONTINUING THERAPY, please specify the	start date (iviivi/ f f).	
Q3. Please indicate the patient's diagnosis for the reques	ted medication: *	
☐ Anemia associated with chronic kidney disease (CKD))	
Anemia associated with myelosuppressive chemothe	rapy	
Anemia associated with zidovudine therapy in a patie	nt with HIV infection	
Reduction of blood transfusions in a patient undergoi	ng elective, non-cardiac, non-va	ascular surgery
☐ Other		
Q4. If the patient's diagnosis is OTHER, please specify	/ below:	
a and patiented alagnosis to aa. s, produce opening		
Q5. Is the patient's pre-treatment hemoglobin level less the	non 10 a/dl 2	
	_	
☐ Yes	☐ No	
Q6. Will there be a dose reduction or interruption if the he	emoglobin level exceeds one of	the following: 10 g/dL (adult
CKD not on dialysis, or cancer); 11 g/dL (CKD on dialysis	<u> </u>	
☐ Yes	□ No	
	□	



ESA-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Prescriber Signatu	 e	



Esbriet-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable)):
*Please note that Envision will process the request as w	vritten, including drug name, wit	h no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may support a estions and sign.	pproval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please specify the s	start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the reques	ted medication:	
☐ Idiopathic pulmonary fibrosis (IPF)	Other	
Q4. If the patient's diagnosis is OTHER, please specify below:		
Q5. Is the prescriber a pulmonologist?		
Yes	□ No	
Q6. Will the patient's hepatic function and liver function te	sts (LFTs) be monitored?	
☐Yes	□No	



Esbriet-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
Prescriber Signature	Date



Farydak-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if appl	licable):
*Please note that Envision will process the request as v	vritten, including drug nam	e, with no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informatio	n for this nationt that may sun	nnort annroval. Please answer the
	estions and sign.	port approval. I lease allower the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	1
Q2. For CONTINUING THERAPY, please provide the	start date (MM/YY):	
, p	(
Q3. Please indicate the patient's diagnosis for the reques	ted medication:	
☐ Multiple myeloma	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify	/ below:	
Q5. Is the patient 18 years of age or older?		
	□No	
Yes	□ No	
Q6. Will Farydak be used in combination with bortezomib	(Velcade) and dexamethaso	one?
☐ Yes	□No	
Q7. Has the patient received at least two (2) prior regime agent [eg, Revlimid (lenalidomide), Thalomid (thalidomide)		lcade) and an immunomodulatory
☐ Yes	□ No	
Q8. Is the requested medication being prescribed by (or i	n consultation with) an oncol	ogist/hematologist?



Prescriber Signature

EOC ID:

Farydak-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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: Prescriber Name:** ☐ Yes ☐ No

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Date



Fentanyl Oral-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

	T	
Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if	fapplicable):
*Please note that Envision will process the request as v	written, including drug	name, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informatio	on for this patient that may uestions and sign.	support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	erany
Q2. For CONTINUING THERAPY, please specify the	start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the reques	sted medication:	
☐ Breakthrough cancer pain (in an opioid-tolerant	□ 0 #	
patient)	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specifi	y holow:	
Q4. If the patient's diagnosis is OTTEN, please specing	y below.	
Q5. Is the patient 16 years of age or older?		
☐ Yes	☐ No	
Q6. If the patient is taking any strong or moderate cytocy	vrome P450 (CVP450) 34	A inhihitore (euch as anrenitant
clarithromycin, diltiazem, erythromycin, fosamprenavir, fli	, , ,	• • •
ritonavir, verapamil) will they be monitored or have dosin		
∏Yes		
∏ No		
☐ N/A - Patient is not taking any strong CYP450 3A4 in	hibitors	
		Will the notions require a supplify
Q7. The plan has the following quantity limits in place: 12	zo lozeriges per 30 days.	vviii trie patierit require a quantity



Fentanyl Oral-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
greater than this?	
☐Yes	□ No
Q8. If the patient requires a quantity greater than specifie exception:	d above, please provide rationale for a quantity limit
Prescriber Signature	Date



Filgrastim-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if	applicable):
*Please note that Envision will process the request as w	vritten, including drug ı	name, with no substitution.
	☐ Expedited/Urge	nt
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information	a for this nationt that may	cupport approval. Please answer the
	estions and sign.	support approval. Flease allswer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	тару
Q2. For continuing therapy, please specify start date (MM/YY):		
	,	
Q3. Please indicate the patient's diagnosis for the reques	ted medication below: *	
☐ Febrile neutropenia, In non-myeloid malignancies follo	owina mvelosuppressive	chemotherapy: Prophylaxis
☐ Febrile neutropenia, In non-myeloid malignancies, in	• • • •	
marrow transplantation; Prophylaxis		
Febrile neutropenia, In patients with acute myeloid lea	ukemia receiving chemot	herapy; Prophylaxis
Harvesting of peripheral blood stem cells		
Hematopoietic subsyndrome of acute radiation syndrome	ome	
Neutropenic disorder, chronic (Severe), Symptomatic		
☐ Other		
Q4. For patients with non-myeloid malignancies receiving	ng myelosuppressive ch	emotherapy, please select if any of the
following apply to this patient:		
☐ Patient experienced febrile neutropenia with a p	orior chemotherapy cycle	
☐ The patient is at high risk (greater than 20%) or	intermediate risk (10-20	%) for developing febrile neutropenia
☐ Patient is at low risk (less than 10%) but is at significant is at significant part of the part of	gnificant risk for serious r	medical consequences due to febrile
neutropenia and the intent of chemotherapy is to prol	=	-
☐ For the treatment of febrile neutropenia in patie	nts who have received pr	ophylaxis with Neupogen or Zarxio



Filgrastim-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:	
(or Leukine) OR in patients at risk for infection-related complications ☐ None of the above		
Q5. If the patient's diagnosis is OTHER, please specify	y below:	
Q6. Are the patient's complete blood count and platelet c	ount being monitored at baseline, and regularly thereafter?	
☐Yes	□ No	
Q7. Please indicate if any of the following apply to this patient (select all that apply): Administration within 24 hours preceding or following chemotherapy or radiotherapy E. coli hypersensitivity For prophylaxis of febrile neutropenia: use to increase the chemotherapy dose intensity or dose schedule beyond established regimens Treatment of febrile neutropenia, when patient receives Neulasta during the current chemotherapy cycle None of the above		
Prescriber Signature	 Date	



Firdapse-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):
*Please note that Envision will process the request as	s written, including drug	name, with no substitution.
	☐ Expedited/Urg	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informat		y support approval. Please answer the
following	questions and sign.	
Q1. Is this request for initial or continuing therapy?		
	Continuing the	orany
☐ Initial therapy	☐ Continuing the	егару
Q2. For CONTINUING THERAPY, please provide th	e start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requi	ested medication:	
☐ Lambert-Eaton myasthenic syndrome (LEMS)	☐ Other	
Q4. If the patient's diagnosis is OTHER, please spec	rify helow:	
Q4. If the patient's diagnosis is 3 TTER, please spec	my below.	
Q5. Is the patient 18 years of age or older?		
	□ Na	
Yes	☐ No	
Q6. Does the patient have a history of seizures?		
☐ Yes	□No	
_		
Prescriber Signature		Date

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Firdapse-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:

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Galafold-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	. Helle.
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if a	applicable):
*Please note that Envision will process t	he request as written, including drug n	ame, with no substitution.
	☐ Expedited/Urgen	t
Drug Name and Strength:		
Directions / SIG:		
Directions / SIG.		
Please attach any pertinent medical histo	ory or information for this patient that may s following questions and sign.	support approval. Please answer the
Q1. Is this request for initial or continuing	therapy?	
☐ Initial therapy	Continuing thera	эру
Q2. For CONTINUING THERAPY, plea	ase indicate the start date (MM/YY):	
Q3. Please indicate the patient's diagnos	is for the requested medication:	
☐ Fabry disease	☐ Other	
Q4. If the patient's diagnosis is OTHEF	R. please specify below:	
Q5. Does the patient have an amenable	galactosidase alpha gene (GLA) mutation	?
☐ Yes	□No	
Q6. Is the patient 18 years of age or olde	 r?	
☐Yes	□No	



Galafold-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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: Prescriber Name:** Prescriber Signature Date



Gilotrif-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
	1	Dhana
Member/Subscriber Number: Date of Birth:	Fax: Office Contact:	Phone:
Group Number:	NPI:	State Lic ID:
Address:	Address:	State Lie 15.
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):
*Please note that Envision will process the request a	as written, including drug	name, with no substitution.
	☐ Expedited/Urg	ent
Drug Name and Strength:		
D' (212		
Directions / SIG:		
Please attach any pertinent medical history or information	ation for this patient that ma	y support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	erapy
Q2. For CONTINUING THERAPY, please provide t	he start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the req	uested medication:	
Non-small cell lung cancer (NSCLC), metastati		
Non-small cell lung cancer (NSCLC), metastati		ated)
Other	o oquamodo (proviodory trot	atouj
Q4. Has the patient's disease progressed following	platinum-based chemother	rapy?
☐ Yes	□No	
Q5. If the patient's diagnosis is OTHER, please spe	ecify below:	
Q6. Do the patient's tumors have non-resistant epider FDA-approved test?	mal growth factor receptor	(EGFR) mutations as detected by an
☐ Yes	☐ No	
Q7. Is the patient 18 years of age or older?		
☐ Yes	□No	



Prescriber Signature

EOC ID:

Gilotrif-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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: Prescriber Name:** Q8. Is the requested medication being prescribed by (or in consultation with) an oncologist? ☐ Yes ☐ No

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Date



Gocovri-4 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name	(if applicable):
*Please note that Envision will process the request a	as written, including drug	name, with no substitution.
	☐ Expedited/Urg	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or inform following	ation for this patient that ma g questions and sign.	ay support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing th	erapy
Q2. For CONTINUING THERAPY, please provide	the start date (MM/YY):	
Q3. For CONTINUING THERAPY, has the patient decreased "off" periods, or decreased "on" time with		·
☐ Yes	☐ No	
Q4. Please indicate the patient's diagnosis for the req	quested medication:	
☐ Parkinson disease	☐ Other	
Q5. If the patient's diagnosis is OTHER, please spe	ecify below:	
Q6. Please check all that apply to this patient:		
☐ Patient is experiencing dyskinesia		
Patient is receiving levodopa based therapy		
Patient has tried and failed amantadine immediate release		
☐ None of the above		
Q7. Does the patient have end stage renal disease (E	ESRD) (CrCl below 15 mL/r	nin/m2)?



Gocovri-4 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
Yes	□No
Q8. Is the requested medication being prescribed by (or i	in consultation with) a neurologist?
☐ Yes	□ No
Prescriber Signature	 Date



Growth Hormone-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if	applicable):
*Please note that Envision will process the request as v	vritten, including drug n	name, with no substitution.
	☐ Expedited/Urger	nt
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may lestions and sign.	support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing ther	ару
Q2. For CONTINUING THERAPY, please specify the s	start date (MM/YY):	
Q3. For CONTINUING THERAPY (ADULT PATIENTS), please select all that ap	oply:
☐ Patient has seen clinical improvement		
☐ IGF-1 will be monitored		
☐ None of the above		
Q4. Please indicate the patient's diagnosis for the reques	ted medication:	
		in a madiatric nations because and for
Growth failure in children		in a pediatric patient born small for
Growth failure associated with chronic kidney	gestational age (SG	one Deficiency (GHD) in neonates with
disease (CKD)	hypoglycemia	one Deliciency (GHD) in neonates with
☐ Growth failure associated with Noonan Syndrome ☐ Growth failure associated with Prader-Willi		one Deficiency (GHD) in pediatrics
Syndrome		one Deficiency (GHD) in adults
Growth failure associated with short stature		• ' '
homeobox gene (SHOX) deficiency	☐ Idiopathic shor	i siaiuic
Growth failure or short stature associated with	☐ Other	
Turner Syndrome		



Growth Hormone-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:
Q5. For GROWTH FAILURE ASSOCIATED WITH CKI Metabolic, endocrine, and nutritional abnormalit The patient has not had a kidney transplant None of the above	
Q6. For GROWTH FAILURE ASSOCIATED WITH TUR confirmed by genetic testing?	RNER SYNDROME OR SHOX, has the diagnosis been
☐Yes	□ No
Q7. For GROWTH FAILURE IN A PATIENT BORN SH low birth weight or length for gestational age?	IORT FOR GESTATIONAL AGE (SGA), did the patient have a
☐Yes	□ No
Q8. For GHD IN NEONATES WITH HYPOGLYCEMIA The patient has a randomly assessed growth he Other causes of hypoglycemia have been ruled Other treatments have been ineffective None of the above	ormone (GH) level less than 20 ng/mL
Q9. For PEDIATRIC GHD, please select all that apply: The patient has delayed bone age The patient does not have pituitary disease, and The patient has pituitary or CNS disorder, and h	
and has low IGF-1	GHD-like symptoms
Q11. For IDIOPATHIC SHORT STATUTE, has pediatr	ic GHD been ruled out with at least one (1) stimulation test? ☐ No
Q12. If the patient's diagnosis is OTHER, please speci-	fy below:
Q13. Please select the prescriber's specialty below:	



Growth Hormone-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
☐ Gastroenterologist ☐ Infectious disease (ID) specialist ☐ Nutritional support specialist ☐ Pediatric nephrologist ☐ None of the above	
Q14. Please indicate the patient's age below: Under 2 years of age 2-3 years of age 3 years of age or older	
Q15. For PEDIATRIC PATIENTS, please select all that a The patient has short stature or slow growth velocit The patient has been evaluated for other causes of None of the above	ty
Prescriber Signature	 Date



Hepatitis C-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):
*Please note that Envision will process the requ	uest as written, including drug	name, with no substitution.
	☐ Expedited/Urg	ent
Drug Name and Strength:		
Directions / SIC:		
Directions / SIG:		
Please attach any pertinent medical history or in	formation for this patient that ma	y support approval. Please answer the
	owing questions and sign.	
Q1. Is this request for initial or continuing therapy	v?	
☐ Initial therapy	, ☐ Continuing the	erapy
.,		
Q2. For CONTINUING THERAPY, please pro-	vide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the	e requested medication:	
☐ Chronic Hepatitis C	☐ Other	
Q4. If the patient's diagnosis is OTHER, pleas	o specify holow:	
Q4. If the patient's diagnosis is OTTLIX, pleas	e specify below.	
OF Disease in disease the accessible decrease like held	la	
Q5. Please indicate the prescriber's specialty bel	IOW.	
Gastroenterologist		
☐ Hepatologist☐ Infectious Disease Specialist☐		
Other		
- Other		
Q6. If the prescriber's specialty is OTHER, ple	ease specify:	
Q7. Please provide the patient's genotype confire	med by HCV RNA level within th	e last 6 months (must submit
documentation):		



Hepatitis C-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
Q8. Please provide the patient's subtype (must submit do	ocumentation):
Q9. Please provide the patient's HCV RNA (viral load) le	vel (must submit documentation):
Q10. Is the patient post-transplant?	
☐Yes	□ No
Q11. What is the patient's cirrhosis status?	
Q12. What is the patient's prior treatment history?	
Q13. What is the patient's planned duration of treatment?	?
Q14. Has the prescriber documented the following within AST/ALT, 3) Total Bilirubin, 4) Serum Albumin, 5) PT/INF	
☐Yes	□ No
Q15. For Vosevi: Has the patient previously tried and fail Yes No N/A - The request is for Mavyret	led (or had a contraindication or intolerance to) Mavyret?
Prescriber Signature	



Hepatitis C-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name

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Hetlioz-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name	(if applicable):
*Please note that Envision will process the request a	as written, including drug	name, with no substitution.
	☐ Expedited/Urg	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informa following	ation for this patient that mag	ay support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing th	erapy
Q2. For CONTINUING THERAPY, please provide t	he start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requ	uested medication:	
☐ Non-24-hour-sleep-wake disorder (Non-24)	☐ Other	
Q4. If the patient's diagnosis is OTHER, please spe	ecify below:	
Q5. Is the patient 18 years of age or older?		
☐ Yes	□No	
Prescriber Signature		Date



Hetlioz-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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: Prescriber Name:** Prescriber Signature Date



HRM ADHD-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Pate of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
ddress:	Address:	
city, State ZIP:	City, State ZIP:	
rimary Phone:	Specialty/facility name (i	f applicable):
Please note that Envision will process the	request as written, including drug	name, with no substitution.
	☐ Expedited/Urge	ent
rug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history	or information for this patient that may following questions and sign.	y support approval. Please answer the
	-	
Q1. Is this request for initial or continuing the	rapy?	
☐ Initial	☐ Continuing	
Q2. For continuing therapy, please specify	v start date (MM/YY):	
Q3. Is the patient greater than or equal to 65	years of age?	
☐Yes	□No	
Q4. Please indicate the diagnosis for which t	he requested medication is being pro	escribed:
Attention deficit hyperactivity disorder (A	DHD)	
Hypertension		
☐ Other		
Q5. If the diagnosis is OTHER, please spe	-:£.	
~~	ecity.	



HRM ADHD-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Na	me:
Prescriber Signature		Date



HRM Analgesics-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (i	f applicable):
Please note that Envision will process the re	equest as written, including drug	name, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions / CIC.		
Directions / SIG:		
Please attach any pertinent medical history o	r information for this patient that may	v support approval. Please answer the
	following questions and sign.	y support approvant rouge anower and
Q1. Is this request for initial or continuing ther	apy?	
☐ Initial therapy	☐ Continuing the	erapy
Q2. For continuing therapy, please specify	start date (MM/YY):	
0 13.1	, ,	
Q3. Is the patient greater than or equal to 65	vears of age?	
_ Yes	,	
Q4. Please indicate the diagnosis for which th	ne requested medication is being pre	escribed:
☐ Tension or muscle contraction headache		
Acute Pain		
Osteoarthritis		
Gout		
Ankylosing Spondylitis		
Rheumatoid Arthritis		
☐ Other		



Prescriber Signature

EOC ID:

HRM Analgesics-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231 Rx 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: Prescriber Name:**

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Date



HRM Anti-Arrhythmics-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

ember/Subscriber Number: ate of Birth: oup Number: Idress:	Fax: Office Contact: NPI: Address:	Phone:	
oup Number: dress:	NPI:		
dress:			
	Address:	State Lic ID:	
0.1.710	<u> </u>		
ty, State ZIP:	City, State ZIP:		
imary Phone:	Specialty/facility name (if	Specialty/facility name (if applicable):	
lease note that Envision will process the r	equest as written, including drug	name, with no substitution.	
	☐ Expedited/Urge	nt	
ug Name and Strength:			
rections / SIG:			
Please attach any pertinent medical history o		support approval. Please answer the	
	following questions and sign.		
O1. In this request for initial or continuing there	any?		
Q1. Is this request for initial or continuing ther	_		
☐ Initial	☐ Continuing		
Q2. For continuing therapy, please specify	start date (MM/YY):		
Q3. Please indicate the patient's diagnosis be	elow:		
☐ Ventricular arrhythmia	☐ Other		
Q4. If the diagnosis is OTHER, please spe	nifv		
Q ii ale diagnosio io o i i i = i i, piedeo ope	y.		
Q5. Is the patient greater than or equal to 65	vears of age?		
	<u> </u>		
☐ Yes	□ No		
Q6. FOR PRESCRIBER INFORMATION ONI	_Y: For patients greater than or equa	al to 65 years, coverage	
determination is approved for FDA-approved			
control preferred for atrial fibrillation.			



HRM Anti-Arrhythmics-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

review process.	he number listed above. Please note any information left blank or illegible may delay the
Patient Name:	Prescriber Name:
Prescriber Signature	Date



HRM Antidepressants-8 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if	applicable):
*Please note that Envision will process the request as	written, including drug	name, with no substitution.
	☐ Expedited/Urge	nt
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information	on for this patient that may	support approval. Please answer the
	uestions and sign.	
O1 to this request for initial or continuing thereby?		
Q1. Is this request for initial or continuing therapy?		
│		
Q2. For continuing therapy, please specify start date (MM/YY):		
Q3. Please indicate which medication is being requested	 <u> </u> :	
☐ Amitriptyline		
☐ Doxepin		
☐ Clomipramine (Anafranil)		
☐ Imipramine HCI (Tofranil)		
☐ Imipramine Pamoate (Tofranil-PM)		
☐ Trimipramine (Surmontil)		
None of the above		
☐ Other		
_		
Q4. If medication is Other, please specify:		
Q5. Please provide the patient's diagnosis below:		
Obsessive-Compulsive Disorder		
☐ Depression		
Anxiety		



HRM Antidepressants-8 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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. Proscribor Namo: **Patient Name:**

ratient Name.	Frescriber Name.
☐ Enuresis ☐ Other	
Q6. If the diagnosis is OTHER, please specify.	
Q7. Is the patient greater than or equal to 65 years of age	e?
☐Yes	□ No
Prescriber Signature	 Date



HRM Antiemetics-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
nary Phone: Specialty/facility name (if applicable):		
*Please note that Envision will process the request as	written, including drug	name, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
D: 12 1010		
Directions / SIG:		
Please attach any pertinent medical history or informati	ion for this patient that may	/ support approval. Please answer the
	questions and sign.	, острои артогания неше аненея инс
		1
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	erapy
Q2. For CONTINUING THERAPY, please indicate Start Date (MM/YY):		
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,	
Q3. Please indicate which medication is requested:		
Hydroxyzine		
☐ Promethazine		
☐ Trimethobenzamide		
Other		
_		
Q4. If medication is Other, Please specify:		
Q5. Is the patient 65 years of age or older?		
☐ Yes	☐ No	
Q6. Please indicate the patient's diagnosis for the reque	ested medication:	
☐ Pruritus/Allergic conditions		
Sedation		
Anxiety/tension		
☐ Nausea/Vomiting		



HRM Antiemetics-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
☐ Motion sickness	
☐ Adjunct to analgesia	
☐ Other	
Q7. If the patient's diagnosis is OTHER, please specify	below:
Q8. FOR PRESCRIBER INFORMATION ONLY: Formula granisetron, ondansetron. Allergic Reactions: levocetirizing	ry non-HRM alternatives are as follows: Nausea/Vomiting: ne
Prescriber Signature	Date



HRM Antihistamines-4 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	_		
Member/Subscriber Number:	Fax:	Phone:		
Date of Birth:	Office Contact:			
Group Number:	NPI:	State Lic ID:		
Address:	Address:			
City, State ZIP:	City, State ZIP:	City, State ZIP:		
Primary Phone:	Specialty/facility name (if a	Specialty/facility name (if applicable):		
*Please note that Envision will process th	e request as written, including drug na	ame, with no substitution.		
	☐ Expedited/Urgent			
Drug Name and Strength:				
D:1: (010				
Directions / SIG:				
Please attach any pertinent medical histor	ry or information for this patient that may s	upport approval. Please answer the		
	following questions and sign.			
O1 to this request for initial or continuing t	horany2			
Q1. Is this request for initial or continuing t	_			
☐ Initial therapy	Continuing thera	ру		
Q2. For continuing therapy, please specify start date (MM/YY):				
Q3. Please indicate the patient's diagnosis	s below:			
☐ Allergic/vasomotor rhinitis				
☐ Allergic conjunctivitis				
☐ Urticaria				
☐ Hypersensitivity reaction				
☐ Other				
Q4. If the diagnosis is OTHER, please s	enecify helow:			
Q4. If the diagnosis is Official, please of	pecify below.			
Q5. Is the patient greater than or equal to	65 years of age?			
Yes	□ No			
☐ 1 cs	□ NO			



HRM Antihistamines-4 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
Prescriber Signature	



HRM Antiparkinson Agents-4 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name	(if applicable):
*Please note that Envision will process the reques	t as written, including drug	name, with no substitution.
	☐ Expedited/Urg	jent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or inform followi	nation for this patient that ma ng questions and sign.	y support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing th	erapy
	•	
Q2. For continuing therapy, please specify start d	ate (MM/YY):	
Q3. Please indicate the patient's diagnosis below:		
Parkinson's disease		
Extrapyramidal disease - Medication-induced	movement disorder	
☐ Other		
OA If the discussion is OTUED above asset follows		
Q4. If the diagnosis is OTHER, please specify bel	OW:	
Q5. Is the patient greater than or equal to 65 years of	of age?	
Yes	☐ No	



HRM Antiparkinson Agents-4 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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: Prescriber Name:**

Date

Prescriber Signature



HRM Antipsychotics-6 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (i	f applicable):
*Please note that Envision will process the re	equest as written, including drug	name, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions / OIC.		
Directions / SIG:		
Please attach any pertinent medical history o	r information for this nationt that ma	v support approval. Please answer the
r least attach any pertinent medical mistory o	following questions and sign.	y support approval. I lease allower the
Q1. Is this request for initial or continuing ther	apy?	
	☐ Continuing	
│		
		- (MM/YY)·
Q2. If the request is for CONTINUING THE		e (MM/YY):
Q2. If the request is for CONTINUING THE	ERAPY, please provide the start date	e (MM/YY):
Q2. If the request is for CONTINUING THE	RAPY, please provide the start date	e (MM/YY):
Q2. If the request is for CONTINUING THE	ERAPY, please provide the start date	e (MM/YY):
Q2. If the request is for CONTINUING THE Q3. Please indicate the patient's diagnosis for Schizophrenia	RAPY, please provide the start date r the requested medication:	e (MM/YY):
Q2. If the request is for CONTINUING THE	RAPY, please provide the start date r the requested medication:	e (MM/YY):
Q2. If the request is for CONTINUING THE Q3. Please indicate the patient's diagnosis for Schizophrenia Q4. If the patient's diagnosis is OTHER, ple	RAPY, please provide the start date r the requested medication: Other ease specify below:	e (MM/YY):
Q2. If the request is for CONTINUING THE Q3. Please indicate the patient's diagnosis for Schizophrenia	RAPY, please provide the start date r the requested medication: Other ease specify below:	e (MM/YY):



HRM Antipsychotics-6 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
Prescriber Signature	Date



HRM Barbiturates-5 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name: Prescriber Name:			
Member/Subscriber Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Group Number:	NPI:	State Lic ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Primary Phone:	Specialty/facility name (if appli	cable):	
*Please note that Envision will process the request as written, including drug name, with no substitution.			
☐ Expedited/Urgent			
Drug Name and Strength:			
Directions / SIG:			
Please attach any pertinent medical history or informatio following qu	n for this patient that may suppuestions and sign.	port approval. Please answer the	
Q1. Is this request for initial or continuing therapy?			
☐ Initial therapy	☐ Continuing therapy		
Q2. For continuing therapy, please specify start date (I	MM/YY):		
Q3. Please indicate the diagnosis for which the requested	d medication is being prescrib	ed:	
Seizure Disorder	.		
☐ Anxiety			
☐ Insomnia			
☐ Other			
Q4. If the diagnosis is OTHER, please specify below:			
Q5. Is the patient greater than or equal to 65 years of age	e?		
☐ Yes	☐ No		
Q6. FOR PRESCRIBER INFORMATION ONLY: Formula (citalopram, escitalopram, fluvoxamine, sertraline, duloxe trazodone.	-	•	



HRM Barbiturates-5 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay t review process.	
Patient Name:	Prescriber Name:
Prescriber Signature	Date



HRM Dementia Agents-4 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name: Prescriber Name:		
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if	applicable):
*Please note that Envision will process the request as w	ritten, including drug r	name, with no substitution.
	☐ Expedited/Urger	nt
Drug Name and Strength:		
Directions / SIG:		
Sirections / Gree.		
Please attach any pertinent medical history or information		support approval. Please answer the
following que	estions and sign.	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing ther	тару
Q2. If the request is for CONTINUING THERAPY, pleas	se provide the start date	(MM/YY):
	•	,
Q3. Please indicate the patient's diagnosis for the request	ed medication:	
☐ Dementia (progressive, Alzheimer's, or senile onset)	☐ Other	
Q4. If diagnosis is OTHER, please specify below:		
and additional to a second speed, second		
Q5. Is the patient 65 years of age or older?		
	□No	
☐ Yes	□ No	
Q6. FOR PRESCRIBER INFORMATION ONLY: Formular	y non-HRM alternatives	are as follows: Antidementia:
donepezil, galantamine, memantine ER, rivastigmine caps	ule, rivastigmine patch.	



HRM Dementia Agents-4 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx manages the pharmacy drug benefit for your patient. Certain requestions and fax this form to the number listed ab review process.	sts for coverage require review with the prescribing physician. Please pove. Please note any information left blank or illegible may delay the
Patient Name:	Prescriber Name:
Prescriber Signature	 Date



HRM Estrogens-7 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if	applicable):
Please note that Envision will process t	he request as written, including drug r	name, with no substitution.
	☐ Expedited/Urger	nt
Orug Name and Strength:		
Dinastiana (OIO)		
Directions / SIG:		
Please attach any pertinent medical hist	ory or information for this patient that may	support approval. Please answer the
	following questions and sign.	
	W	
Q1. Is this request for initial or continuing	_	
☐ Initial therapy	☐ Continuing ther	тару
Q2. For continuing therapy, please spe	ecify start date (MM/YY):	
	,	
O3 Please indicate the diagnosis for whi	ch this modication is boing proscribed:	
Q3. Please indicate the diagnosis for whi	• •	
Atrophia wyka (vagina (Moderate to S	•	
☐ Atrophic vulva/vagina (Moderate to S☐ Prevention of postmenopausal osteo		
· · ·	y to hypogonadism, castration, or primary	ovarian failure
☐ Breast cancer, Metastatic; for palliation	, , ,	ovarian failure
Prostate cancer, Advanced, Androge	•	
Other	n-dependent, for paniation only	
Q4. If the patient's diagnosis is OTHE	R, please specify below.	
Q5. Is the patient greater than or equal to	o 65 years of age?	
☐Yes	□No	
00 500 005000055 1150517551	ONLY 5 1 11511 11 11	<u> </u>
	ONLY: Formulary non-HRM alternatives steoporosis: Alendronate and Risedronat	
i romann Oreani and Estradioi Oreani. O	sicoporosis. Alcharonaic ana Miscaronai	U.



HRM Estrogens-7 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:	
Prescriber Signature	 Date	



HRM Muscle Relaxant-8 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name	(if applicable):
*Please note that Envision will process the request as	written, including dru	g name, with no substitution.
	☐ Expedited/Ur	gent
Drug Name and Strength:		
D: 11 1010		
Directions / SIG:		
Please attach any pertinent medical history or information	on for this nationt that m	ay sunnort annroyal Plaasa answer the
	uestions and sign.	ay support approval. I lease allower the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	nerapy
Q2. If the request is for CONTINUING THERAPY, plea	ase provide the start da	ate (MM/YY):
Q2. If the request is for deliving the recovery, plea	ase provide the start de	(WIND 1 1).
Q3. Please indicate the patient's diagnosis for the reques	sted medication:	
Acute Painful Musculoskeletal conditions		
Chronic Intermittent Painful Musculoskeletal condi	tions	
☐ Fibromyalgia		
Restless Leg Syndrome		
☐ Nocturnal Leg Cramps		
☐ Other		
Q4. If the patient's diagnosis is OTHER, please specif	····	
Q4. If the patient's diagnosis is OTHEN, please specif	у.	
OF to the postions are also the control to OF to	-2	
Q5. Is the patient greater than or equal to 65 years of ag		
Yes	☐ No	



HRM Muscle Relaxant-8 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
Prescriber Signature	Date



HRM Oncology-6 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (i	f applicable):
Please note that Envision will process the r	equest as written, including drug	name, with no substitution.
	☐ Expedited/Urge	ent
Orug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history of	or information for this patient that may following questions and sign.	y support approval. Please answer the
	Tonowing quotions and signi	
Q1. Is this request for initial or continuing the	rany?	
_ '	<u>_</u>	orony.
☐ Initial therapy	☐ Continuing the	егару
Q2. If the request is for CONTINUING THE	ERAPY, please provide the start date	e (MM/YY):
Q3. Please indicate the diagnosis for which the	he requested medication is being pre	escribed: *
Cachexia associated with AIDS	,	
☐ Breast cancer, palliative treatment of adv	anced disease	
☐ Endometrial carcinoma, palliative treatme		
☐ Other		
Q4. If the diagnosis is OTHER, please spe	eaify halow	
Q4. If the diagnosis is OTHER, please spe	city below.	
Q5. Is the patient greater than or equal to 65	years of age?	
Q5. Is the patient greater than or equal to 65	years or age?	



HRM Oncology-6 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
Prescriber Signature	



HRM Platelet Inhibitors-4 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (i	f applicable):
Please note that Envision will process the	e request as written, including drug	name, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions / SIG:		
onections / GIG.		
Please attach any pertinent medical history	or information for this patient that may	y support approval. Please answer the
	following questions and sign.	
Q1. Is this request for initial or continuing the	nerapy?	
☐ Initial therapy	☐ Continuing the	erapy
Q2. For continuing therapy, please speci	fv start date (MM/YY):	
3	,	
Q3. Please indicate the patient's diagnosis	below:	
☐ Heart valve replacement - Thromboe		
Cerebrovascular accident; Prophylax	· · ·	
Other		
OA If the discussion of OTLIED places of	if . h - l	
Q4. If the diagnosis is OTHER, please sp	decily below.	
Q5. Is the patient greater than or equal to 6	5 years of age?	
☐ Yes	☐ No	
	NII V. Farmaniam , man I IDM alternatives	and as follows: Distolat Inhibitors:
Q6. FOR PRESCRIBER INFORMATION O	INLY: FORMULARY NON-HRIVI AlleMalives	s are as iollows. Platelet inhibitors:



Fax back to: 877-503-7231

EOC ID:

HRM Platelet Inhibitors-4 Medicare

Phone: 800-361-4542

Rx 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:	Prescriber Name:
Prescriber Signature	Date



HRM Sedative Hypnotics-7 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name ((if applicable):
*Please note that Envision will process the request a	as written, including drug	name, with no substitution.
	☐ Expedited/Urg	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informa		ay support approval. Please answer the
following	g questions and sign.	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing th	erapy
Q2. For CONTINUING THERAPY, please indicate	Start Date (MM/YY):	
Q3. Please indicate the patient's diagnosis:		
☐ Insomnia	☐ Other	
Q4. If the patient's diagnosis is OTHER, please spe	ecify below:	
Q5. Is the patient greater than or equal to 65 years of	age?	
☐ Yes	☐ No	



HRM Sedative Hypnotics-7 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
Prescriber Signature	Date



Humira-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

		_
Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax: Phone:	
Date of Birth:	Office Contact:	
Group Number:	NPI: State Lic ID:	
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone: Specialty/facility name (if applicable):		
*Please note that Envision will process the request as wr	ritten, including drug name, with no substitution.	
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information	for this patient that may support approval. Please answer the	_
	stions and sign.	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For continuing therapy, please specify the start date (MM/YY):		
der i de continuing archapy, produce opeony are start date		
O2 Plages indicate the nationt's diagnosis for the requests	nd modication:	_
Q3. Please indicate the patient's diagnosis for the requeste	_	
Ankylosing Spondylitis	☐ Polyarticular juvenile idiopathic arthritis (pJIA)	
Crohn's Disease (moderate to severe)	(moderate to severe)	
Hidradenitis suppurativa (moderate to severe)	Psoriatic arthritis	
Non-infectious Uveitis (including intermediate, posterio	· · · <u></u> -	
and panuveitis)	Ulcerative colitis (moderate to severe)	
Plaque psoriasis (chronic)	☐ Other	
I	se affect more than 5% of the body surface area (BSA) or	
affect crucial body areas such as the hands, feet, face, or	or genitals?	
☐ Yes	□ No	
Q5. If the patient's diagnosis is OTHER, please specify t	pelow:	
Q6. Has the patient tried and failed (or has a contraindicati that apply)?	on or intolerance to) any of the following (please select all	



Humira-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:
☐ RA or pJIA - one or more non-biologic disease modifying anti-rheumatic drugs (DMARDs) for at least 3 consecutive months ☐ PSORIATIC ARTHRITIS - methotrexate ☐ ANKYLOSING SPONDYLITIS - one or more non-steroidal anti-inflammatory drugs (NSAIDs) ☐ PLAQUE PSORIASIS - conventional therapy with phototherapy (such as UVA with a psoralen [PUVA] and/or retinoids [RePUVA]) for at least one continuous month ☐ PLAQUE PSORIASIS - conventional therapy with one or more oral systemic treatments (such as cyclosporine, acitretin, sulfasalazine, methotrexate, leflunomide, azathioprine) for at least 3 consecutive months	☐ CROHN'S DISEASE - two or more corticosteroids or non-biologic DMARDs ☐ ULCERATIVE COLITIS - two or more corticosteroids, 5-ASA (such as mesalamine, sulfasalazine, balsalazide), or non-biologic DMARDs (azathioprine, cyclosporine, hydroxychloroquine, leflunomide, sulfasalazine) ☐ UVEITIS - one of the following: systemic or topical corticosteroids or ophthalmic antimuscarinics ☐ None of the above
Q7. Please indicate the patient's age below: Under 2 years 2-5 years 6-11 years 12-17 years old 18 years or older	
Q8. Does the patient have any active serious infections (i	ncluding tuberculosis [TB])?
☐Yes	□ No
Q9. Will the patient be using Humira in combination with a immunosuppressant (such as azathioprine or cyclosporin	a biologic disease-modifying anti-rheumatic drugs or potent e)?
☐Yes	□ No
Prescriber Signature	Date



Humira-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name

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Ibrance-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
 Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name ((if applicable):
*Please note that Envision will process the reques	st as written, including drug	name, with no substitution.
	☐ Expedited/Urg	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or info	rmation for this patient that ma ving questions and sign.	ay support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	erapy
Q2. For CONTINUING THERAPY, please indica	ite the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the r	requested medication:	
☐ Breast cancer, advanced or metastatic	☐ Other	
Q4. If the patient's diagnosis is OTHER, please	specify below:.	
Q5. Is the patient's disease hormone receptor (HR) negative?)-positive, human epidermal g	rowth factor receptor 2 (HER2)-
☐ Yes	☐ No	
Q6. Please indicate how the requested medication	will be used:	
☐ In combination with an aromatase inhibitor in therapy ☐ In combination with fulvestrant in a woman w	·	
☐ None of the above	, , ,	<u> </u>
Q7. Is the patient 18 years of age or older?		



Ibrance-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
☐Yes	□ No
Q8. Is the medication prescribed by (or in consultation with	th) an oncologist?
☐Yes	□ No
Prescriber Signature	 Date



Iclusig-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Nam	e:
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	i none.
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility	name (if applicable):
*Please note that Envision will proce	ss the request as written, including	g drug name, with no substitution.
	☐ Expedi	ted/Urgent
Drug Name and Strength:		
Directions / SIG:		
Siredions / Gio.		
Please attach any pertinent medical		that may support approval. Please answer the
	following questions and sign	
Q1. Is this request for initial or contin	uing therapy?	
☐ Initial therapy ☐ Continuing therapy		
Q2. If the request is for CONTINUI	NG THERAPY, please provide the st	art date (MM/YY):
Q3. Please indicate the patient's diag	nosis for the requested medication:	
Acute lymphoblastic leukemia, Pl	niladelphia chromosome-positive (Ph	+ALL)
	(chronic, accelerated, or blast phase)
☐ Other		
Q4. If the patient's diagnosis is OT	HER, please specify below:	
Q5. Please select if any of the followi	ng apply to this patient (please selec	t all that apply):
	tor therapy is indicated for this patien	
☐ The patient is T315I-positive		
☐ None of the above		
Q6. Please indicate the prescriber's s	specialty below:	
☐ Hematologist	☐ Oncologist	Other
Q7. If the prescriber's specialty is OTHER, please specify below:		



Fax back to: 877-503-7231

EOC ID:

Phone: 800-361-4542

Iclusig-2 Medicare

Rx 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:	Prescriber Name:
Prescriber Signature	 Date



Idhifa-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
	1	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	0
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	eflilab.
Primary Phone:	Specialty/facility name (іт арріісаріе):
*Please note that Envision will process the request as v	written, including drug	name, with no substitution.
	☐ Expedited/Urg	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informatio	n for this patient that ma uestions and sign.	y support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
	Continuing the	
☐ Initial therapy	☐ Continuing the	егару
Q2. For CONTINUING THERAPY, please provide the	start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the reques	sted medication:	
☐ Acute myeloid leukemia (AML), relapsed/refractory	<u></u>	
Q4. If the patient's diagnosis is OTHER, please specify	y below:	
Q5. Does the patient have an an isocitrate dehydrogenas	se 2 mutation as detecte	d by an FDA approved test?
☐ Yes	□ No	
Q6. Is the patient 18 years of age or older?		
☐ Yes	☐ No	
Q7. Is the requested medication prescribed by (or in cons	sultation with) a hematol	ogist or oncologist?
☐ Yes	☐ No	
I .		



Idhifa-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:	
Prescriber Signature		



Inbrija-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:		
Member/Subscriber Number:	Fax:	Phone:	
Date of Birth:	Office Contact:	Fhorie.	
Group Number:	NPI:	State Lic ID:	
Address:	Address:	State 2.6 15.	
City, State ZIP:	City, State ZIP:		
Primary Phone:	Specialty/facility name (if applicable):		
*Please note that Envision will process the reque	est as written, including drug	name, with no substitution.	
□ Expedited/Urgent			
Drug Name and Strength:			
Directions / SIG:			
Please attach any pertinent medical history or info	ormation for this patient that ma wing questions and sign.	y support approval. Please answer the	
Q1. Is this request for initial or continuing therapy?	?		
☐ Initial therapy	☐ Continuing the	erapy	
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):			
Q3. Please indicate the patient's diagnosis for the	requested medication:		
☐ Parkinson's disease ☐ Other			
Q4. If the patient's diagnosis is OTHER, please specify below:			
Q5. Will the requested medication be used concur	rently with carbidopa/levodopa	?	
☐ Yes	□No		
Q6. Has the patient tried and failed (or has contra	indication to) one generic formu	ulary alternative?	
` Yes	, S □ No	,	
Q7. Is the patient 18 years old or older?			
☐ Yes	☐ No		
Q8. Do any of the following apply to this patient (p	lease select all that apply)?		
☐ The patient is currently taking a nonselectiv	e monoamine oxidase inhibitor	(MAOI) (such as phenelzine or	



Prescriber Signature

EOC ID:

Inbrija-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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: Prescriber Name:** tranylcypromine) ☐ The patient has recently (within 2 weeks) taken a nonselective MAOI ☐ None of the above

Date



Imbruvica-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:		
Member/Subscriber Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Group Number:	NPI:	State Lic ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Primary Phone:	Specialty/facility name (if application)	able):	
*Please note that Envision will process the request as w	vritten, including drug name,	with no substitution.	
☐ Expedited/Urgent			
Drug Name and Strength:			
Directions (OIO)			
Directions / SIG:			
Please attach any pertinent medical history or information	n for this patient that may suppo	ort approval. Please answer the	
	estions and sign.		
Q1. Is this request for initial or continuing therapy?			
☐ Initial therapy	☐ Continuing therapy		
Q2. If the request is for CONTINUING THERAPY, plea	se provide the start date (MM/	YY):	
α, μ	(/.	
Q3. Please indicate the patient's diagnosis for the reques	ted medication:		
☐ Chronic graft-versus-host-disease (cGVHD) (after fail		temic therapy)	
☐ Chronic lymphocytic leukemia (CLL) with or without 1		ternio trierapy)	
Mantle cell lymphoma (MCL) (in patients who have received at least 1 prior therapy)			
☐ Marginal zone lymphoma, relapsed/refractory (in patients who require systemic therapy and have received at least 1			
prior anti-CD20-based therapy)			
☐ Small lymphocytic lymphoma (SLL) with or without 17p deletion			
☐ Waldenstrom macroglobulinemia			
☐ Other			
Q4. If the patient's diagnosis is OTHER, please specify	below:		
, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			



Imbruvica-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:	
Prescriber Signature	Date	



Increlex-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:		
		D)	
Member/Subscriber Number:	Fax:	Phone:	
Date of Birth:	Office Contact:	State Lic ID:	
Group Number:	NPI: Address:	State Lic ID:	
Address: City, State ZIP:	City, State ZIP:		
		unnlicable):	
•	rimary Phone: Specialty/facility name (if applicable):		
*Please note that Envision will process t	he request as written, including drug n	ame, with no substitution.	
	☐ Expedited/Urgen	t	
Drug Name and Strength:			
Directions / SIC:			
Directions / SIG:			
Diagon official any northwest modical biotes	and an information for this nations that may re	number approval Places approve the	
Please attach any pertinent medical histo	ory or information for this patient that may s following questions and sign.	support approval. Please answer the	
Q1. Is the request for initial or continuing	therapy?		
☐ Initial therapy	☐ Continuing thera	anv	
Q2. For CONTINUING THERAPY, plea	ase specify the start date (MM/YY):		
Q3. Please indicate the patient's diagnosi	is for the requested medication: *		
	tor-1 deficiency (IGF-1 deficiency; primary	(IGED)	
	in a patient that has developed neutralizin	•	
☐ Genetic mutation of GH receptor (i.e.		g annual control grown members	
Other			
OA If the discussion is OTHED release.	and affects of a large		
Q4. If the diagnosis is OTHER, please	specify below:		
Q5. Does the patient have severe growth	retardation with height standard deviation	score (SDS) more than 3 SDS	
below the mean for chronological age and	d sex?		
☐ Yes	□No		
00 to the make the 105 4 to only the	an an anval to 0 atomic and device them.	. manusal based on let reference	
Q6. Is the patient's IGF-1 level greater that range for age and sex?	an or equal to 3 standard deviations below	normal based on lab reference	
Yes	☐ No		



Increlex-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Pi	rescriber Name:	
Q7. Does the patient have normal or elevated growth hormone (GH) levels based on at least one growth hormone stimulation test?			
☐ Yes		☐ No	
Q8. Is there evidence of open ep	iphyses?		
☐ Yes		□No	
Q9. Does the patient have allergi	es to mecasermin or any co	omponent of the Incre	lex formulation?
☐ Yes		☐ No	
Q10. Will the medication be used	I for growth promotion in pa	tients with closed epip	physes?
☐ Yes		☐ No	
Q11. Will Increlex be administere	ed intravenously?		
☐ Yes		☐ No	
Q12. Does the patient have activ	e or suspected neoplasia?		
☐ Yes		☐ No	
Q13. Please indicate the prescrib	per's specialty below:		
☐ Pediatrics	☐ Endocrinologi	st	☐ Other
Q14. If the prescriber's specialty is other, please describe below:			
Prescriber Sign	ature		 Date



Inrebic-12 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (i	f applicable):
Please note that Envision will process the request a	as written, including drug	name, with no substitution.
	☐ Expedited/Urge	ent
Orug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informa		y support approval. Please answer the
Jillwollol	g questions and sign.	
O1. In the request for initial or continuing therapy?		
Q1. Is the request for initial or continuing therapy?		
☐ Initial therapy	Continuing the	erapy
Q2. For CONTINUING THERAPY, please provide t	he start date (MM/YY):	
O2 Diagon indicate the national diagnosis for the reg	usated modication:	
Q3. Please indicate the patient's diagnosis for the req		
Myelofibrosis (MF), intermediate-2 or high-risk p or secondary (post-polycythemia vera or post-essentia thrombocythemia)		
Q4. If the patient's diagnosis is OTHER, please spe	ecify below:	
Q5. Is the patient 18 years of age or older?		
☐Yes	□No	
Q6. Is the requested medication prescribed by, or in c	onsultation, with an oncolog	gist or hematologist?
☐Yes	☐ No	
Prescriber Signature		Date



Inrebic-12 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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: Prescriber Name:



Intrarosa-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Group Number:	NPI:	State Lic ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Primary Phone:	Specialty/facility name (if applicable):		
*Please note that Envision will process the re	equest as written, including drug	name, with no substitution.	
	☐ Expedited/Urge	ent	
Drug Name and Strength:			
Directions / SIG:			
Please attach any pertinent medical history of	r information for this patient that may following questions and sign.	support approval. Please answer the	
Q1. Is this request for initial or continuing there	apy?		
☐ Initial therapy	☐ Continuing the	rapy	
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):			
Q3. Please indicate the patient's diagnosis for	the requested medication:		
☐ Dyspareunia (moderate to severe)	•		
☐ Atrophic vaginitis			
☐ Other			
Q4. If the patient's diagnosis is OTHER, ple	ease specify below:		
Q5. Is the patient's condition caused by meno	pause?		
☐Yes	□No		
00 to the method 40 man of a new collection			
Q6. Is the patient 18 years of age or older?	_		
Yes	□ No		
Q7. Does the patient have any of the following	g (please select all that apply)?		
☐ Vaginal bleeding or dysfunctional uterin	e bleeding of an undetermined origi	n	
☐ Known or suspected estrogen-depende	ent neoplasia		



Prescriber Signature

EOC ID:

Intrarosa-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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: Prescriber Name:** ☐ None of the above

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Date



Iressa-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (it	f applicable):
*Please note that Envision will process the request as	written, including drug	name, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
D' (* / 010		
Directions / SIG:		
Please attach any pertinent medical history or information	on for this natient that may	support approval. Please answer the
	uestions and sign.	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	rapy
Q2. For CONTINUING THERAPY, please provide the	start date (MM/YY):	
	,	
Q3. Please indicate the patient's diagnosis for the reque	sted medication:	
☐ Non-small cell lung cancer (metastatic)	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specif	fy below:	
Q5. Does the patient have known active epidermal grow	th factor receptor (EGFR)	exon 19 deletions or exon 21
(L858R) substitution mutations as detected by an FDA-a	• •	
Amendments-approved facility?		
☐ Yes	☐ No	
Q6. Is the medication prescribed by (or in consultation w	rith) an oncologist?	
☐ Yes	, □ No	
Q7. Is the patient 18 years old or older?		
☐ Yes	☐ No	



Iressa-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

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.		the
Patient Name:	Prescriber Name:	
Prescriber Signatu	re Date	



Iron Overload-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if	applicable):
*Please note that Envision will process the	request as written, including drug r	name, with no substitution.
	☐ Expedited/Urger	nt
Drug Name and Strength:		
Directions / SIG:		
Sirections / Gig.		
Please attach any pertinent medical history	or information for this patient that may following questions and sign.	support approval. Please answer the
Q1. Is this request for initial or continuing th	erapy?	
☐ Initial therapy	☐ Continuing ther	гару
Q2. For CONTINUING THERAPY, please	e specify the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis	for the requested medication below: *	
☐ Chronic iron overload in nontransfusion	al-dependent thalassemia syndromes	
☐ Chronic iron overload due to blood trans	•	
☐ Other		
Q4. If the patient's diagnosis is OTHER,	please specify below:	
Q5. Please indicate the patient's age:		
Under 2 years	☐ 2 years and old	dor.
☐ Officer 2 years		uei
Q6. What is the patient's serum creatinine le	evel?	
Q7. What is the patient's serum ferritin level	?	
Q8. Is the requested medication prescribed	by a hematologist?	
	<u> </u>	



Iron Overload-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
☐ Yes	□ No
Prescriber Signatur	Date



Itraconazole-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if	applicable):
*Please note that Envision will process t	the request as written, including drug n	name, with no substitution.
	☐ Expedited/Urger	nt
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history	ory or information for this patient that may following questions and sign.	support approval. Please answer the
Q1. Is the request for initial or continuing	therapy?	
☐ Initial therapy	☐ Continuing ther	ару
Q2. For continuing therapy, please spe	ecify start date (MM/YY):	
Q3. Please indicate the diagnosis for whi	ich Itraconzole is being requested: *	
	pergillosis, histoplasmosis, blastomycosis)
Onychomycosis		
, , , ,	aryngeal) that is refractory to treatment wi	th fluconazole (ORAL SOLUTION
ONLY)		
Other		
Q4. If the diagnosis is OTHER, please	specify below:	
Q5. For ONYCHOMYCHOSIS, has the d preparation, fungal culture, or nail biopsy	iagnosis has been confirmed with a fungar)?	al diagnostic test (e.g., KOH
☐ Yes	□No	
Prescriber Signature		Date



Itraconazole-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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: Prescriber Name:



IVIG-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:		
Member/Subscriber Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Group Number:	NPI:	State Lic ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Primary Phone:	Specialty/facility name	(if applicable):	
*Please note that Envision will process the requ	est as written, including drug	g name, with no substitution.	
	☐ Expedited/Urg	gent	
Drug Name and Strength:			
D' 1' 1010			
Directions / SIG:			
Please attach any pertinent medical history or inf	ormation for this patient that ma	ay support approval. Please answer the	
folic	wing questions and sign.		
Q1. Is the request for initial or continuing therapy	· · · · · · · · · · · · · · · · · · ·		
☐ Initial therapy			
<u> </u>		етару	
Q2. For continuing therapy, please specify star	t date (MM/YY):		
Q3. Please indicate the diagnosis for which IVIG	therapy is being requested:		
☐ Acute and chronic immune Idiopathic Thromb	ocytopenic Purpura (ITP)		
☐ Chronic inflammatory demyelinating polyneur			
☐ Primary humoral immunodeficiency syndrome	e (congenital agammaglobuline	mia, severe combined immunodeficiency	
syndromes [SCIDS], common variable immunode	eficiency, X-linked immunodefi	ciency, Wiskott-Aldrich syndrome)	
Prevention of bacterial infection in patients wi	th hypogammaglobulinemia an	d/or recurrent bacterial infections with B-	
cell chronic lymphocytic leukemia (CLL)			
Prevention of coronary artery aneurysms assu		ie .	
Motor neuropathy with multiple conduction blo	DCK		
☐ Other			
Q4. For CIDP: Has diagnosis been confirmed b	y a neurologist?		
☐ Yes	☐ No		
Q5. If the diagnosis is OTHER, please specify	below:		
and analysis is a many process opposity	 		



IVIG-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:		Prescriber Name:	
Q6. Does the patient have	gA deficiency with antibody for	ormation and a history of hypersensitivity?	
☐ Yes		□ No	
Q7. Does the patient have	a history of anaphylaxis or sev	vere systemic reaction to human immune globulin?	
☐ Yes	□No		
·	any risk factor(s) for acute ren	al failure, unless the patient will receive IVIG products at the e of infusion practicable?	
☐ Yes		□ No	
		outside of a controlled healthcare setting, will appropriate an acute hypersensitivity reaction?	
☐ Yes	□No	☐ Not applicable	
Prescrib	per Signature	 Date	



Juxtapid-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (i	f applicable):
*Please note that Envision will process the request as	written, including drug	name, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informati following of	ion for this patient that may questions and sign.	y support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	erapy
Q2. For CONTINUING THERAPY, please provide the	e start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the reque	ested medication:	
☐ Homozygous familial hypercholesterolemia	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify below:		
Q5. Has the patient had an inadequate response or into	elerance to statins?	
☐Yes	□No	
Q6. Does the patient have any of the following (please sometimes) Moderate to severe liver impairment Active liver disease including unexplained persist Pregnant Concemitant use with strong or moderate CVP34	ent abnormal liver function	n tests
☐ Concomitant use with strong or moderate CYP3A4 inhibitors ☐ None of the above		



Fax back to: 877-503-7231

EOC ID:

Phone: 800-361-4542

Juxtapid-3 Medicare

Rx 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:	Prescriber Name:
Prescriber Signature	Date



Kalydeco-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applical	ble):
*Please note that Envision will process the request as v	vritten, including drug name, v	with no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:	. •	
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may supportestions and sign.	rt approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
.,		
Q2. For CONTINUING THERAPY, please provide the	start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the reques	ted medication:	
☐ Cystic fibrosis	Other	
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Does the patient have 1 mutation in the cystic fibrosis responsive to Kalydeco potentiation based on clinical and		regulator (CFTR) gene that is
	-	
Yes	□ No	
Q6. For CONTINUING THERAPY, has the patient experience therapy?	enced improved or stable lung for	unction while on Kalydeco
Yes	□ No	



Kalydeco-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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: Prescriber Name:** Prescriber Signature Date



Kisqali-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):
*Please note that Envision will process the request	as written, including drug	name, with no substitution.
	☐ Expedited/Urg	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or inform following	nation for this patient that ma ng questions and sign.	y support approval. Please answer the
	.9 4	
Q1. Please indicate which medication this request is	for:	
☐ Kisqali	☐ Kisqali Femar	~a
☐ Kisqaii		a
Q2. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	erapy
Q3. For CONTINUING THERAPY, please provide	the start date (MM/YY):	
Q4. Please indicate the patient's diagnosis for the re-	quested medication:	
☐ Breast cancer (advanced or metastatic)	☐ Other	
Q5. If the patient's diagnosis is OTHER, please sp	ecify below:	
Q6. Please select all that apply to this patient:		
☐ The patient is a postmenopausal female		
☐ The patient is a premenopausal or perimenopausal female		
☐ The patient's disease is hormone receptor (HF	R)-positive	
☐ The patient's disease is human epidermal grov	· ·)-negative
☐ The medication will be used in combination with		
☐ The medication will be used in combination will		
disease progression on endocrine therapy (does not		
	•	· ·



Kisqali-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
☐ None of the above	
Q7. Is the patient 18 years of age or older?	
Yes	□No
Q8. Is the requested medication prescribed by (or in cons	ultation with) an oncologist?
Yes	□No
Prescriber Signature	Date



Korlym-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (i	f applicable):
*Please note that Envision will process the request as	written, including drug	name, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following q	on for this patient that may uestions and sign.	/ support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	erapy
Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):		
Q3. Please indicate the patient's diagnosis for the reques	sted medication: *	
☐ Hyperglycemia (in a patient with endogenous		
Cushing's syndrome who has failed surgery or who is	☐ Other	
ineligible for surgery)		
Q4. If the patient's diagnosis is OTHER, please specif	y below:	
	•	
Q5. Is the patient pregnant?		
☐ Yes		
□ No		
☐ Patient is not female		



Korlym-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx manages the pharmacy drug benefit for your patient. Certain requestions and fax this form to the number listed at review process.	sts for coverage require review with the prescribing physician. Please pove. Please note any information left blank or illegible may delay the
Patient Name:	Prescriber Name:
Prescriber Signature	Date



Kuvan-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone: Specialty/facility name (if applicable):		
*Please note that Envision will process the request as wi	ritten, including drug	name, with no substitution.
	☐ Expedited/Urg	gent
Drug Name and Strength:		
D' (210		
Directions / SIG:		
Please attach any pertinent medical history or information	for this patient that ma	ay support approval. Please answer the
	estions and sign.	,
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing Th	nerapy
Q2. For continuing therapy, please specify start date (M	M/YY):	
	,	
Q3. Please indicate the diagnosis for which the requested	medication is being pr	rescribed: *
☐ To reduce blood phenylalanine (Phe) levels in patien	ts 🗆 out	
with hyperphenylalaninemia (HPA)	☐ Other	
Q4. If the diagnosis is OTHER, please specify below:		
Q 1. If the diagnosis is 3 friend, pieces spoonly below.		
Q5. What is the patient's age?		
	□ 0	10
12 years or younger	☐ Greater than	12 years
Q6. What is the pretreatment blood phenylalanine (Phe) le	vel?	
☐ Greater than or equal to 10mg/dl		
☐ Between 6mg/dl and 10mg/dl		
Less than 6mg/dl		
Q7. Will blood Phe levels be checked after 1 week of thera	py and periodically un	to one month during a therapeutic
trial?	, ,	3
☐ Yes	□No	



Kuvan-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
Q8. For CONTINUING THERAPY, is there a response to a therapeutic trial as defined by greater than or equal to 30% reduction in baseline Phe levels?	
☐ Yes	□ No
Prescriber Signature	Date



Kynamro-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable	e):
*Please note that Envision will process the request as w	ritten, including drug name, wi	th no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
D: 12 / 202		
Directions / SIG:		
Please attach any pertinent medical history or information	for this natient that may support	annroval Please answer the
	estions and sign.	approvan r iodoo anomor mo
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the s	start date (MM/YY):	
7, 1111, 1111	,	
Q3. Please indicate the patient's diagnosis for the request	ted medication:	
☐ Homozygous familial hypercholesterolemia	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Has the patient tried and failed or had an intolerance	to statins?	
☐Yes	□No	
Q6. Does the patient have moderate to severe liver impair abnormal liver function tests?	rment or active liver disease inclu	ding unexplained persistent
☐ Yes	□ No	
Q7. For CONTINUING THERAPY, has the patient respon	ded to therapy with a decrease in	LDL levels?
☐ Yes	□ No	
□ 102		



Fax back to: 877-503-7231

EOC ID:

Phone: 800-361-4542

Kynamro-1 Medicare

Rx 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:	Prescriber Name:
Prescriber Signature	Date



Lenvima-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if app	olicable):
*Please note that Envision will process the request as v	vritten, including drug nan	ne, with no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Disease office have nowinger modical history or information	n for this nations that may are	nnout annuaval. Diagge anguses the
Please attach any pertinent medical history or information following qu	n for this patient that may su lestions and sign.	pport approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therap	у
Q2. For CONTINUING THERAPY, please provide the	start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the reques	ted medication:	
☐ Differentiated thyroid cancer (locally recurrent or meta	astatic, progressive)	
☐ Endometrial carcinoma (advanced)		
☐ Hepatocellular carcinoma (unresectable)		
Renal cell carcinoma (advanced)		
☐ Other		
Q4. If the patient's diagnosis is OTHER, please specify	holow.	
Q4. If the patient's diagnosis is OTHER, please specify	below.	
Q5. For ENDOMETRIAL CARCINOMA, please select all	that apply to the patient:	
☐ The patient's disease is not microsatellite instability	/-high (MSI-H) or mismatch	repair deficient (dMMR)
☐ The requested medication will be used in combinate	tion with pembrolizumab (Ke	eytruda)
☐ The patient has had disease progression following	prior systemic therapy	
☐ The patient is not a candidate for curative surgery	or radiation	
☐ None of the above		



Lenvima-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:	
Q6. For RENAL CELL CARCINOMA, has the pa	atient received at least one (1) prior anti-angiogenic therapy?	
☐Yes	☐ Yes ☐ No	
Q7. For RENAL CELL CARCINOMA, will the re (Afinitor)?	quested medication be used in combination with everolimus	
☐ Yes	□ No	
Q8. For THYROID CANCER, is the patient's dis	ease refractory to radioactive iodine?	
☐Yes	□ No	
Prescriber Signature	Date	



Letairis-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if	applicable):
*Please note that Envision will process the request as v	vritten, including drug	name, with no substitution.
	☐ Expedited/Urge	nt
Drug Name and Strength:		
Directions / SIG:		
Directions / Gro.		
Please attach any pertinent medical history or information following qu	n for this patient that may lestions and sign.	support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	rapy
Q2. For CONTINUING THERAPY, please specify the s	start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the reques	ted medication:	
☐ Pulmonary arterial hypertension (PAH), WHO Grou	p I 🔲 Other	
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. For PAH, has the diagnosis been confirmed by right unable to undergo a right heart catheterization (e.g., patie	ent is frail, elderly, etc.)?	Ooppler echocardiogram if patient is
Yes	☐ No	
Q6. Is the patient pregnant?		
☐Yes	□No	
Q7. For FEMALE PATIENTS OF CHILD-BEARING POTE	ENTIAL, please select all	that apply:
☐ Pregnancy has been excluded prior to the start of t☐ The patient has been educated about the potential☐ Women of childbearing potential will be using an IU.	herapy hazards associated with	Letairis use in pregnancy



Prescriber Signature

EOC ID:

Letairis-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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: Prescriber Name:** ☐ None of the above ☐ N/A - The patient is not a female of child-bearing potential

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Date



Leukine-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name ((if applicable):
*Please note that Envision will process the requ	est as written, including drug	name, with no substitution.
	☐ Expedited/Urg	jent
Drug Name and Strength:		
D' 1' 1010		
Directions / SIG:		
Please attach any pertinent medical history or inf	ormation for this patient that ma	y support approval. Please answer the
	owing questions and sign.	,
Q1. Is this request for initial or continuing therapy	?	
☐ Initial therapy	☐ Continuing th	erany
Q2. For continuing therapy, please specify star	t date (MM/YY):	
Q3. Please indicate the diagnosis for which Leuki	ne is being requested:	
Acute myelogenous leukemia (AML), following	g induction chemotherapy	
Bone marrow transplant (allogeneic or autolog	- ,	ay
Myeloid reconstitution after allogeneic bone m	•	
Myeloid reconstitution after autologous bone	•	odgkin's lymphoma (NHL), acute
lymphoblastic leukemia (ALL), Hodgkin's lympho Peripheral stem cell transplantation: Mobilizat		following autologous peripheral etem cell
transplantation	lion and myelold reconstitution	iollowing autologous peripheral sterri cell
Other		
Q4. For AML only, is there excessive (greater t	han or equal to 10%) leukemic	myeloid blasts in the hone marrow or
peripheral blood?	inari or equal to 1070/ leakerine	mycloid blasts in the bone marrow of
Yes		
□ No		
☐ N/A - patient does not have AML		
Q5. If the diagnosis is OTHER, please specify	below:	
The state of the s		



Leukine-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Q6. For patients with nonmyeloid malignancies receiving myelosuppressive chemotherapy, please check all that apply: Leukine is being used for the prevention of chemotherapy-induced febrile neutropenia and the patient has experienced febrile neutropenia with a prior chemotherapy cycle The patient is at high risk (greater than 20%) for developing febrile neutropenia The patient is at intermediate risk (10-20%) for developing febrile neutropenia. The patient at low risk (less than 10%) for developing febrile neutropenia and there is a significant risk for serious medical consequences due to febrile neutropenia and the intent of chemotherapy is to prolong survival or cure the disease. None of the above		
Q7. Is Leukine being requested for treatment of febrile neutropenia in a patient who has received prophylaxis with Leukine (or Neupogen)?		
☐Yes	□No	
Q8. Will patient receive baseline and regular monitoring of complete blood counts and platelet counts?		
☐ Yes	□No	
Q9. Is patient at risk for infection-related complications?		
☐Yes	□No	
Q10. Will Leukine be administered within 24 hours preceding or following chemotherapy or radiotherapy?		
☐Yes	□No	
Q11. Is Leukine being used for prophylaxis to to increase the chemotherapy dose intensity or dose schedule above established regimens?		
☐Yes	□No	
Q12. For treatment of febrile neutropenia: Did the patient receive Neulasta during the current chemotherapy cycle?		
☐Yes	□ No	
Q13. Does patient have a known hypersensitivity to yeas	t-derived products?	
☐ Yes	□ No	



Leukine-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

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Patient Name:	Prescriber Name:
Prescriber Signature	 Date



Lidocaine Patch-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable	le):
*Please note that Envision will process the request as t	written, including drug name, w	vith no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informatio		approval. Please answer the
following qu	uestions and sign.	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please indicate the	start date below (MM/YY):	
Q3. Does the patient have postherpetic neuralgia?		
☐ Yes	□No	
Q4. Does the patient have diabetic peripheral neuropathy	y?	
☐ Yes	□ No	
Q5. If the diagnosis is NOT postherpetic neuralgia or dial diagnosis below:	betic peripheral neuropathy, pleas	se specify the patient's
Q6. Has the patient previously tried and failed (or had an medications which are labeled for the treatment of diabet Cymbalta Lyrica Other None of the above		-



Lidocaine Patch-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
Q7. If the medication is OTHER, please specify below:	
Q8. If the patient has NOT tried any of the medications listed in the previous questions, is there a reason these medications cannot be used (i.e. contraindication, history of adverse event, etc)?	
Prescriber Signature	 Date



Lorbrena-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

	T	
Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):
*Please note that Envision will process the request as	written, including drug	name, with no substitution.
	☐ Expedited/Urg	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information	on for this patient that ma luestions and sign.	y support approval. Please answer the
	acononio una oigin	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	orany
ппиагинетару		етару
Q2. For CONTINUING THERAPY, please provide the	start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the reque	sted medication:	
☐ Non-small cell lung cancer (NSCLC), metastatic	☐ Other	
, , ,		
Q4. If the patient's diagnosis is OTHER, please specif	fy below:	
Q5. Is the patient anaplastic lymphoma kinase (ALK)-pos	sitive?	
☐ Yes	☐ No	
Q6. Has the patient experienced disease progression on	n any of the following (ple	ease select all that apply)?
Alectinib (Alecensa)		
Ceritinib (Zykadia)		
Crizotinib (Xalkori) AND at least 1 other ALK inhib	itor for metastatic diseas	e
☐ None of the above		
Q7. Will the patient be taking this medication in combina	tion with a strong CYP3A	A inducer?
☐ Yes	□No	



Lorbrena-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
Q8. Is the patient 18 years of age or older?	
☐ Yes	□ No
Q9. Is the requested medication being prescribed by (or i	n consultation with) an oncologist?
☐ Yes	□ No
Prescriber Signature	Date



Lupron-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
	Fax:	Phone:
Date of Birth:	Office Contact:	i none.
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):
*Please note that Envision will process the request a	s written, including drug	name, with no substitution.
	☐ Expedited/Urg	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informa	tion for this patient that ma	y support approval. Please answer the
Tollowing	questions and sign.	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	erapy
Q2. For CONTINUING THERAPY, please indicate S	Start Date (MM/YY):	
Q3. Please indicate which medication the request is fo	 r:	
Leuprolide		
Lupron Depot Injection 3.75 mg		
☐ Lupron Depot Injection 7.5 mg		
☐ Lupron Depot Injection 11.25		
☐ Lupron Depot Injection 22.5 mg		
Lupron Depot Injection 30 mg		
Lupron Depot Injection 45 mg		
☐ Other		
Q4. If medication is Other, Please specify:		
Q5. Please indicate the patient's diagnosis for the requ	uested medication:	
☐ Prostate cancer (advanced or metastatic) ☐ Endometriosis		
☐ Anemia due to uterine Leiomyomata (Fibroids)		



Lupron-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
☐ Central precocious puberty (idiopathic or neurogenic) ☐ Other	in children
Q6. For ANEMIA DUE TO UTERINE LEIOMYOMATA	(FIBROIDS), please select all that apply:
☐ Patient is preoperative	☐ None of the above
Q7. If the patient's diagnosis is OTHER, please specify	below.
Q8. For FEMALE PATIENTS, select all that apply:	
☐ Patient is pregnant	
☐ Patient is breastfeeding	
☐ Patient has undiagnosed abnormal vaginal bleedin☐ None of the above	9
Q9. Will the patient be utilizing non-hormonal contraceptive	ves during and for 12 weeks after therapy?
☐Yes	□ No
Prescriber Signature	 Date



Lynparza-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

	T	
Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):
*Please note that Envision will process the request as v	vritten, including drug	name, with no substitution.
	☐ Expedited/Urg	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informatio	n for this patient that ma ıestions and sign.	y support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	erany
		этару
Q2. If the request is for CONTINUING THERAPY, plea	ase provide the start dat	e (MM/YY):
Q3. Please indicate which medication this request is for:		
	☐ Lynparza tabl	ets
Q4. Please indicate the patient's diagnosis for the reques	sted medication:	
☐ Breast cancer, metastatic		
☐ Epithelial ovarian, fallopian tube, or primary peritonea	al cancer (recurrent)	
Ovarian cancer, advanced		
☐ Other		
Q5. For METASTATIC BREAST CANCER, please sele	ect all that apply to this	patient:
☐ The patient's disease is human epidermal grow		
☐ The patient by deleterious or suspected deleter	·	, -
☐ The patient has been previously treated with ch	<u> </u>	,-
None of the above	iomoundrapy in the need	ajavani, aajavani, oi motaotatio ootiing
Q6. For EPITHELIAL OVARIAN, FALLOPIAN TUBE, (IEAL CANCER, has the patient had a
complete or partial response to platinum-based chemo	шегару?	



Lynparza-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
☐Yes	□ No
Q7. For ADVANCED OVARIAN CANCER, please sele	ct all that apply to this patient:
☐ The patient has deleterious or suspected delete cancer ☐ The patient has been treated with three (3) or m ☐ None of the above	erious germline BRCA-mutated (gBRCAm) advanced ovarian
Q8. If the patient's diagnosis is OTHER, please specify	below:
Prescriber Signature	



Mayzent-12 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (i	f applicable):
*Please note that Envision will process the request as w	ritten, including drug	name, with no substitution.
	☐ Expedited/Urg	ent
Drug Name and Strength:		
Directions / SIG:		
Directions / GIG.		
Please attach any pertinent medical history or information		y support approval. Please answer the
following que	estions and sign.	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	erapy
Q2. For CONTINUING THERAPY, please provide the s	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the request	ed medication:	
Relapsing forms of multiple sclerosis (including		
clinically isolated syndrome, relapsing-remitting disease, or	or	
active secondary progressive disease)		
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Is the patient 18 years of age or older?		
☐ Yes	□No	
Q6. Is the requested medication prescribed by (or in const	ultation with) a neurolog	gist?
☐ Yes	☐ No	
Q7. Does the patient have any of the following (please sel	ect all that apply)?	
CYP2C9*3/*3 genotype	· FF 77	
☐ In the last 6 months, has experienced myocardial in	farction, unstable andir	na, stroke, TIA, decompensated heart
_ , , , , , , , , , , , , , , , , , , ,	, ,	. , , , , , , , , , , , , , , , , , , ,



Mayzent-12 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:		
failure requiring hospitalization, or Class III-IV heart failure Presence of Mobitz type II second-degree, third-degree AV block, or sick sinus syndrome, unless patient has a functioning pacemaker None of the above			
Prescriber Signature	Date		



Mekinist-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable	·):
*Please note that Envision will process the request as w	rritten, including drug name, wi	th no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	itor this patient that may support a estions and sign.	approval. Please answer the
Q1. Is the request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the	start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the reques	ted medication:	
☐ Melanoma (adjuvant treatment)		
☐ Melanoma (unresectable or metastatic)		
☐ Non-small cell lung cancer (metastatic) (with BRAF V	600E mutation)	
☐ Thyroid cancer, anaplastic (locally advanced or metastatic) (with BRAF V600E mutation)		
☐ Other		
Q4. If the patient's diagnosis is OTHER, please specify	below.	
Q5. Does the patient have documented BRAF V600E or \	/600K mutations as detected by a	n FDA-approved test?
☐ Yes	□No	
OC to the very rested medication being a reasonible of burners	naala siat0	
Q6. Is the requested medication being prescribed by an o	_	
Yes	□ No	



Mekinist-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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: Prescriber Name:** Prescriber Signature Date



Mektovi-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (i	f applicable):
*Please note that Envision will process the request as	written, including drug	name, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following q	on for this patient that may uestions and sign.	y support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	erapy
Q2. For CONTINUING THERAPY, please provide the st	art date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the reque	sted medication:	
☐ Melanoma (unresectable or metastatic malignant)	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify t	pelow:	
Q5. Does the patient have BRAF V600E or V600K muta	tion as detected by an FI	DA-approved test?
☐ Yes	☐ No	
Q6. Will Mektovi be used in combination with Braftovi (en	ncorafenib)?	
☐ Yes	☐ No	
Q7. Is the requested medication being prescribed by (or	in consultation with) an o	oncologist?
☐ Yes	□No	
Q8. Is the patient 18 years of age or older?		



Prescriber Signature

EOC ID:

Mektovi-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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: Prescriber Name:** ☐ Yes ☐ No

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error, please notify the sender immediately to arrange for the return of this document

Date



Miglustat-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):
*Please note that Envision will process the request as w	vritten, including drug name, wit	h no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may support a estions and sign.	pproval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):		
Q3. Please indicate the patient's diagnosis for the reques	ted medication:	
☐ Gaucher disease, type 1 (mild to moderate)	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify below:		
Q5. Is the patient a candidate for enzyme replacement the	erapy?	
☐ Yes	□ No	
Q6. Is the patient 18 years of age or older?		
☐ Yes	□No	



Miglustat-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:	
Prescriber Signature	Date	



Multiple Sclerosis-5 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name	(if applicable):
*Please note that Envision will process the request a	s written, including drug	g name, with no substitution.
	☐ Expedited/Urg	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informa following	ition for this patient that mails in the control of	ay support approval. Please answer the
	· ·	
Q1. Is this request for initial or continuing therapy?		
│	☐ Continuing th	nerapy
Q2. For CONTINUING THERAPY, please provide the	he start date (MM/YY):	
Q3. For CONTINUING THERAPY, has the patient e	experienced an objective r	esponse to therapy (such as no or
slowed progression of disease)?		
Yes	☐ No	
Q4. Please indicate which medication this request is fo	or:	
☐ Aubagio		
Avonex		
Betaseron		
Gilenya		
Glatiramer		
☐ Plegridy		
☐ Tecfidera		
Q5. For AUBAGIO, please select all that apply to thi	is patient:	
☐ Patient has severe hepatic impairment		
☐ Patient is currently being treated with lefluno	omide	
☐ Patient is pregnant		



Multiple Sclerosis-5 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:	
☐ Patient is a woman of child-bearing potential who is NOT using reliable contraception ☐ None of the above		
Q6. For GILENYA, please select all that apply to this patient:		
Recent (within the last 6 months) occurrence of: myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, or Class III/IV heart failure History or presence of Mobitz Type II 2nd degree or 3rd degree AV block or sick sinus syndrome, unless patient has a pacemaker		
 ☐ Baseline QTc interval greater than or equal to 500 ms ☐ Receiving concurrent treatment with Class Ia or Class III anti-arrhythmic drugs (such as quinidine, procainamide, amiodarone, or sotalol) ☐ None of the above 		
Q7. For GILENYA, will the patient be observed for sign least 6 hours after the first dose?	is and symptoms of bradycardia in a controlled setting for at	
☐ Yes	□ No	
Q8. For GLATIRAMER, is the patient 18 years of age of	or older?	
☐Yes	□ No	
Q9. Please indicate the patient's diagnosis for the reques	ted medication:	
 ☐ Relapsing forms of multiple sclerosis (clinically isol relapsing MS or active secondary progressive disease) ☐ First clinical episode and patient has MRI features ☐ Other 	ated syndrome, relapsing-remitting disease, progressive- consistent with multiple sclerosis	
Q10. If the patient's diagnosis is OTHER, please speci	fy below:	
Prescriber Signature		



Natpara-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):
*Please note that Envision will process the request as	written, including drug	name, with no substitution.
	☐ Expedited/Urg	ent
Drug Name and Strength:		
Directions / OIO		
Directions / SIG:		
Please attach any pertinent medical history or informat	ion for this patient that ma	v support approval. Please answer the
	questions and sign.	, capport approvant loads anone, and
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	Continuing the	erany
☐ Initial therapy	☐ Continuing the	erapy
☐ Initial therapy Q2. If the request is for CONTINUING THERAPY, ple		
	ease provide the start dat	
Q2. If the request is for CONTINUING THERAPY, plo	ease provide the start dat	
Q2. If the request is for CONTINUING THERAPY, plo Q3. Please indicate the patient's diagnosis for the reque ☐ Hypocalcemia due to hypoparathyroidism	ease provide the start date	
Q2. If the request is for CONTINUING THERAPY, plo Q3. Please indicate the patient's diagnosis for the reque	ease provide the start date	
Q2. If the request is for CONTINUING THERAPY, ple Q3. Please indicate the patient's diagnosis for the reque U Hypocalcemia due to hypoparathyroidism Q4. If diagnosis is OTHER, please specify:	ease provide the start datesested medication:	
Q2. If the request is for CONTINUING THERAPY, plo Q3. Please indicate the patient's diagnosis for the reque	ease provide the start datesested medication:	



Natpara-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
Prescriber Signature	Date



Nerlynx-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if a	oplicable):
*Please note that Envision will process the request as v	written, including drug na	me, with no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
D: // / 010		
Directions / SIG:		
Please attach any pertinent medical history or informatio following qu	n for this patient that may suestions and sign.	upport approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing thera	nv
Q2. For CONTINUING THERAPY, please provide the	start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the reques	sted medication:	
☐ Breast cancer (early stage HER2-overexpressed)	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify	y below:	
Q5. Will Nerlynx be used in a patient who has been previ	ously treated with trastuzui	mab-based therapy?
□ Yes	☐ No	
Q6. Is the patient 18 years of age or older?		
☐ Yes	☐ No	
O7 to Northway proposition by (as in proposition with the	anadariat?	
Q7. Is Nerlynx prescribed by (or in consultation with) and	-	
☐ Yes	☐ No	



Nerlynx-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:	
Prescriber Signature	 Date	



Ninlaro-4 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:		
Member/Subscriber Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Group Number:	NPI:	State Lic ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Primary Phone:	Specialty/facility name (if applicable):		
*Please note that Envision will process the request as v	vritten, including drug name	e, with no substitution.	
☐ Expedited/Urgent			
Drug Name and Strength:			
D' - 1' 1010			
Directions / SIG:			
Please attach any pertinent medical history or information	n for this patient that may supp	port approval. Please answer the	
	estions and sign.	on approval rouse allerer alle	
Q1. Is this request for initial or continuing therapy?			
☐ Initial therapy	☐ Continuing therapy		
Q2. For continuing therapy, please specify start date (MM/YY).			
and the second s			
O3 Please indicate the nationt's diagnosis for the regues	ted medication:		
Q3. Please indicate the patient's diagnosis for the requested medication:			
Multiple myeloma	Other		
Q4. If the patient's diagnosis is OTHER, please specify	below.		
Q5. Will the requested medication be used in combination	with lenalidomide (Revlimid)	and dexamethasone?	
·	`	, and dexametrideene.	
Yes	□ No		
Q6. Has the patient received at least one (1) prior therapy	/?		
☐ Yes	□No		
	<u> </u>		
Q7. Is the patient 18 years old or older?			
☐ Yes	☐ No		
Q8. Is the medication prescribed by or in consultation with a hematologist/oncologist?			
as is the medication processed by or in concutation with			



Ninlaro-4 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
☐ Yes	□No
Prescriber Signatu	ure Date



Northera-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Dres sriber Name:	
	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	04-4- 1 :- ID.
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP: Primary Phone:	City, State ZIP:	١.
·	Specialty/facility name (if applicable	
*Please note that Envision will process the request as v	<u>_</u>	
Drug Name and Strength:	☐ Expedited/Urgent	
Directions / SIG:		
Please attach any pertinent medical history or information		pproval. Please answer the
following qu	estions and sign.	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):		
Q2. If the request is for SCIVIIIVOIIVO II LIVE 1, pice	be provide the start date (WWW 17)	•
Q3. Please indicate the patient's diagnosis for the reques	ted medication:	
☐ Neurogenic orthostatic hypotension (NOH)	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify below:		
Q5. If the patient has a diagnosis of NOH, is the NOH due	e to any of the following (please se	elect all that apply)?
☐ Primary autonomic failure (Parkinson's disease, mu	ultiple system atrophy, or pure auto	onomic failure)
Dopamine beta-hydroxylase deficiency		,
☐ Non-diabetic autonomic neuropathy		
☐ None of the above		
Q6. If the patient has NOH that is NOT caused by any	of the issues listed in the provious	guestion, please specify the
cause of the patient's NOH:	of the issues listed in the previous	question, please specify the
cause of the patient effects.		
Q7. Does the patient have any of the following symptoms	(please select all that apply)?	
Orthostatic dizziness	(Figure 2010)	



Prescriber Signature

EOC ID:

Northera-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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: Prescriber Name:** Lightheadedness ☐ "Feeling that you are about to black out" ☐ None of the above

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Date



Nubeqa-12 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:	
леmber/Subscriber Number:	Fax:	Phone:
Pate of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
ddress:	Address:	
ity, State ZIP:	City, State ZIP:	
rimary Phone:	Specialty/facility name	(if applicable):
Please note that Envision will process the request as w	ritten, including drug	g name, with no substitution.
	☐ Expedited/Ur	gent
orug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that meestions and sign.	ay support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	Continuing th	nerapy
Q2. For CONTINUING THERAPY, please provide the s	start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the request	ted medication:	
Prostate cancer (non-metastatic, castration-resistan	t)	
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Is the patient 18 years of age or older?		
Yes	□No	
Q6. Is the requested medication prescribed by (or in cons	ultation with) an oncol	ogist or urologist?
☐Yes	□No	
Prescriber Signature		Date Date

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Nubeqa-12 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:

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Nucala-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if	applicable):
*Please note that Envision will process th	ne request as written, including drug	name, with no substitution.
□ Expedited/Urgent		
Drug Name and Strength:		
Directions / SIG:		
Directions / Sig.		
Please attach any pertinent medical histo	ry or information for this patient that may	support approval. Please answer the
	following questions and sign.	
Q1. Is this request for initial or continuing	therany?	
,	_	rony
☐ Initial therapy	☐ Continuing the	тару
Q2. If the request is for CONTINUING	THERAPY, please provide the start date	(MM/YY):
Q3. Please indicate the patient's diagnosis	s for the requested medication: *	
☐ Severe asthma (Add-on maintenance	treatment)	
☐ Eosinophilic granulomatosis with poly	•	
☐ Other		
Q4. For ASTHMA, does the patient hav	re an eosinophilic phenotype?	
Yes	□ No	
_		
Q5. If the patient's diagnosis is OTHER	, please specify below:	
Q6. Is the requested medication being pre	escribed by a pulmonologist or immunologist	ogist?
☐ Yes	□No	
Prescriber Signature		Date



Nucala-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:



Nuedexta-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (i	f applicable):
*Please note that Envision will process the re	equest as written, including drug	name, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or f	r information for this patient that may following questions and sign.	y support approval. Please answer the
Q1. Is this request for initial or continuing there	apy?	
☐ Initial therapy	☐ Continuing the	erany
Q2. For CONTINUING THERAPY, please s	specify the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for	the requested medication:	
☐ Pseudobulbar affect (PBA)	☐ Other	
Q4. If the patient's diagnosis is OTHER, ple	ase specify below:	



Nuedexta-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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: Prescriber Name:

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Nuplazid-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:		
Member/Subscriber Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Group Number:	NPI:	State Lic ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Primary Phone:	Specialty/facility name (if applicable):		
Please note that Envision will process the request as	written, including drug	name, with no substitution.	
	☐ Expedited/Urge	ent	
Drug Name and Strength:			
Directions (OIO)			
Directions / SIG:			
Please attach any pertinent medical history or informati	on for this patient that may	v support approval. Please answer the	
following c	questions and sign.	y dappoin approval. I loude allower the	
O1 to this request for initial or continuing thereby?			
Q1. Is this request for initial or continuing therapy?			
☐ Initial therapy	☐ Continuing the	erapy	
Q2. If the request is for CONTINUING THERAPY, ple	ease provide the start date	e (MM/YY):	
Q3. Please indicate the patient's diagnosis for the reque	ested medication:		
Q3. Please indicate the patient's diagnosis for the reque			
Q3. Please indicate the patient's diagnosis for the reque	Other		
	☐ Other		
☐ Parkinson's disease - Psychotic disorder	☐ Other		
☐ Parkinson's disease - Psychotic disorder	Other fy below:		
☐ Parkinson's disease - Psychotic disorder Q4. If the patient's diagnosis is OTHER, please speci	Other fy below:		



Nuplazid-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
Prescriber Signature	Date



Octreotide-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if ap	plicable):
*Please note that Envision will process the request as v	vritten, including drug nai	me, with no substitution.
☐ Expedited/Urgent		
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may su estions and sign.	pport approval. Please answer the
O1 to this request for initial or continuing thereby?		
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	Continuing therap	ру
Q2. For continuing therapy, please specify start date (MM/YY):		
Q3. Please indicate the diagnosis for which Octreotide is	being requested:	
☐ Acromegaly		
☐ Metastatic carcinoid tumors		
☐ Watery diarrhea associated with vasoactive intestinal peptide-secreting tumors (VIPomas)		
☐ Other		
Q4. If the patient's diagnosis is OTHER, please specify	below:	



Octreotide-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
Prescriber Signature	Date



Opsumit-6 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name	(if applicable):
*Please note that Envision will process the request as w	ritten, including drug	name, with no substitution.
	☐ Expedited/Urg	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following que	n for this patient that ma estions and sign.	ay support approval. Please answer the
9 4		
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing th	erapy
Q2. For CONTINUING THERAPY, please specify the s	tart date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the request	ed medication:	
☐ Pulmonary arterial hypertension (PAH) (World Healt	h	
Organization group 1)	☐ Other	
O4 If the nationt's diagnosis is OTHER places enceity	holow	
Q4. If the patient's diagnosis is OTHER, please specify	below.	
Q5. Has diagnosis been confirmed by right heart catheteri	ization?	
☐ Yes	☐ No	
Q6. For FEMALE PATIENTS, please select all that apply:		
☐ The patient is enrolled in the OPSUMIT REMS prog	Ji ai i i	
☐ The patient is NOT pregnant ☐ The patient will use an IUD or two appropriate contr	racentive methods	
☐ N/A - The patient is not female or not of child-bearing	•	
	ig poteritial	



Opsumit-6 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
Prescriber Signature	Date



Orkambi-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if a	applicable):
Please note that Envision will process the request as v	vritten, including drug na	ame, with no substitution.
	☐ Expedited/Urgent	t
Orug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informatio following qu	n for this patient that may s lestions and sign.	support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing thera	ару
Q2. If the request is for CONTINUING THERAPY, plea	se provide the start date (MM/YY):
Q3. For CONTINUING THERAPY, is the patient tolera following (please select all that apply)? Improved FEV1 Weight gain Decreased exacerbations Other None of the above	ting and responding to the	medication as evidenced by the
Q4. Please indicate the patient's diagnosis for the reques	ted medication:	
☐ Cystic Fibrosis (CF)	Other	
Q5. If diagnosis is OTHER, please specify below:		
Q6. Is the patient homozygous for the F508del mutation i test?	n the CFTR gene as confi	rmed by an FDA-approved CF
☐ Yes	☐ No	



Prescriber Signature

EOC ID:

Orkambi-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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: Prescriber Name:** Q7. Is the medication prescribed by, or in conjunction with, a pulmonologist or is from a CF center accredited by the Cystic Fibrosis Foundation? ☐ Yes ☐ No

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Date



Orilissa-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):
Please note that Envision will process the request as	written, including drug	name, with no substitution.
	☐ Expedited/Urg	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informati following o	on for this patient that ma questions and sign.	y support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	егару
Q2. For CONTINUING THERAPY, please indicate the	e start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the reque	ested medication:	
☐ Endometriosis (with moderate to severe pain)	☐ Other	
Q4. If the patient's diagnosis is OTHER, please speci	fy below:	
Q5. Is the patient 18 years of age or older?		
☐ Yes	☐ No	
Q6. Does the patient have any of the following (please s	select all that apply)?	
☐ Pregnancy		
☐ Known osteoporosis		
☐ Severe hepatic impairment		
Current use of strong organic anion transporting p	polypeptide (OATP) 1B1 i	nhibitors
☐ None of the above		



Orilissa-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx manages the pharmacy drug benefit for you answer the following questions and fax this form review process.	patient. Certain requests for coverage require review with the prescribing physician. Please to the number listed above. Please note any information left blank or illegible may delay	e y the
Patient Name:	Prescriber Name:	
	·	
Prescriber Signature	 Date	



Osphena-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	ent Name: Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if a	applicable):
*Please note that Envision will process the	e request as written, including drug n	ame, with no substitution.
	☐ Expedited/Urgen	t
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical histor	y or information for this patient that may s following questions and sign.	support approval. Please answer the
Q1. Is this request for initial or continuing the	herapy?	
☐ Initial therapy	☐ Continuing there	ару
Q2. For CONTINUING THERAPY, pleas	se provide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis	for the requested medication:	
☐ Dyspareunia (moderate to severe)		
☐ Atrophic vaginitis		
☐ Moderate to severe vaginal dryness du	ie to menopause	
☐ Other		
Q4. If the patient's diagnosis is OTHER,	please specify below:	
Q5. Is the patient's condition caused by me	enopause?	
☐ Yes	□No	
Q6. Is the patient 18 years of age or older?)	
☐ Yes	□No	
Q7. Does the patient have any of the follow	ving (please select all that apply)?	
	story of thromboembolic disease (includ	ing patients with a history of DVT,



Osphena-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
pulmonary embolism, retinal vein thrombosis, stroke, or	myocardial infarction)
☐ Known or suspected estrogen-dependent neoplasi	a
☐ Known or suspected pregnancy	
☐ Vaginal bleeding or dysfunctional uterine bleeding	of an undetermined origin
☐ None of the above	
Prescriber Signature	Date



Oxandrolone-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
		Dharra
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	Chata Lia ID.
Group Number:	NPI: Address:	State Lic ID:
Address: City, State ZIP:		
Oity, State ZiF. Primary Phone:	City, State ZIP: Specialty/facility name	(if applicable):
•		,
*Please note that Envision will process the request a	as written, including dru	g name, with no substitution.
	☐ Expedited/Ur	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informa following	ation for this patient that m g questions and sign.	ay support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing t	herany
		петару
Q2. For continuing therapy, please specify start dat	e (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requ	uested medication: *	
☐ To promote weight gain (adjunct therapy)	☐ Other	
Q4. If the diagnosis is OTHER, please specify below:		
Q5. Does the patient have any of the following exclusi	one? (Please select all the	at apply):
☐ Known or suspected carcinoma of the prostate☐ Carcinoma of the breast in a female patient with	,	5)
Nephrosis (the nephrotic phase of nephritis)	Ппурегсавсенна	
Hypercalcemia		
☐ Pregnancy		
☐ None of the above		



Oxandrolone-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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: Prescriber Name:** Prescriber Signature Date



Oxervate-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if a	pplicable):
*Please note that Envision will process t	he request as written, including drug na	nme, with no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
2		
Directions / SIG:		
Please attach any pertinent medical histo	ory or information for this patient that may s following questions and sign.	upport approval. Please answer the
O1 to this request for initial or continuing	thorony2	
Q1. Is this request for initial or continuing	• •	
☐ Initial therapy	☐ Continuing thera	ру
Q2. For CONTINUING THERAPY, plea	ase provide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosi	is for the requested medication:	
☐ Neurotrophic keratitis	☐ Other	
Q4. If the patient's diagnosis is OTHEF	R, please specify below:	
Q5. Is the medication being prescribed by	y or in consultation with an ophthalmologisi	t or optometrist?
Yes		
Prescriber Signature		Date



PCSK9 Inhibitors-14 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name	(if applicable):
*Please note that Envision will process the re	equest as written, including drug	g name, with no substitution.
	☐ Expedited/Urg	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history of	r information for this patient that ma following questions and sign.	ay support approval. Please answer the
Q1. Is this request for initial or continuing there	ару?	
☐ Initial therapy	☐ Continuing th	nerapy
Q2. For continuing therapy, please specify	start date (MM/YY):	
Q3. Please indicate which medication this req	uest is for:	
☐ Praluent	☐ Repatha	
Q4. Please indicate the patient's diagnosis for	the requested medication:	
☐ Primary hypercholesterolemia Heterozygo	ous Familial Hypercholesterolemia	(HeFH)
☐ Primary hyperlipidemia Homozygous Fam	ilial Hypercholesterolemia (HoFH)	
Clinical Atherosclerotic Cardiovascular Dis	,	
Myocardial infarction prophylaxis, stroke p	prophylaxis, and to reduce risk of c	oronary revascularization in pts with
established CVD		
Other		
Q5. FOR HeFH: has the diagnosis been co	nfirmed by either of the following?	
☐ Genotyping		
☐ Medically accepted diagnostic criter	ia	
☐ None of the above		
Q6. For HoFH, has the diagnosis been con-	firmed by any of the following? (pla	ease select all that anniv).



PCSK9 Inhibitors-14 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
☐ Genotyping ☐ History of untreated LDL-C greater than 500 mg/dL ☐ Xanthoma before 10 years of age ☐ Documentation of HeFH in both parents ☐ None of the above		
Q7. FOR CARDIOVASCULAR DISEASE: has the patie apply):	ent experienced any of the following? (please select all that	
 ☐ Acute coronary syndrome ☐ History of myocardial infarction ☐ Stable or unstable angina ☐ Coronary or other arterial revascularization ☐ Stroke ☐ Transient ischemic attack (TIA) ☐ Peripheral arterial disease (PAD) presumed to I ☐ None of the above 	pe atherosclerotic region	
Q8. If the patient's diagnosis is OTHER, please specify	below:	
Q9. Please provide the patient's baseline and current LDI	C cholesterol levels below:	
Q10. Please indicate the patient's age: Less than 13 years of age 13-17 years of age 18 years of age or older		
Q11. Please select all that apply to this patient: Patient's LDL-C level is greater than or equal to 70 mg/dL The requested medication will be used in combination with maximally tolerated high-intensity statin therapy Statins are not tolerated by the patient None of the above		
Q12. If statins are contraindicated or not tolerated by the patient, please explain below:		
Q13. Is the medication being prescribed by, or in consulta Cardiologist Endocrinologist Lipid specialist	ation, with any of the following provider specialties?	



PCSK9 Inhibitors-14 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
☐ None of the above	
Q14. FOR CONTINUING THERAPY: please select all that apply to this patient: The requested medication will continue to be used in combination with maximally tolerated statin Statin therapy is not tolerated by the patient None of the above	
Prescriber Signature	



Pegasys-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	F	Prescriber Name:	
Member/Subscriber Number:		Fax:	Phone:
Date of Birth:		Office Contact:	
Group Number:	1	NPI:	State Lic ID:
Address:		Address:	
City, State ZIP:		City, State ZIP:	
Primary Phone:] ;	Specialty/facility nan	ne (if applicable):
*Please note that Envision will pro	cess the request as wri	itten, including dı	rug name, with no substitution.
		☐ Expedited/	Urgent
Drug Name and Strength:			
Directions / SIG:			
Please attach any pertinent medic		for this patient that stions and sign.	may support approval. Please answer the
Q1. Is this request for initial or con-	tinuing therapy?		
☐ Initial therapy		☐ Continuing	therapy
Q2. For continuing therapy, plea	ase specify start date (MN	И/YY):	
Q3. Please indicate the patient's di	iagnosis for the requester	d medication: *	
☐ Chronic Hepatitis B	☐ Chronic Hepa	atitis C	Other
Q4. For CHRONIC HEPATITIS	C, please indicate the pa	tient's genotype be	elow:
Q5. For CHRONIC HEPATITIS		nt naive or experier	nced?
☐ Treatment naive (i.e. no p Hepatitis C)	previous treatment for	☐ Treatmer for Hepatitis C	nt experienced (i.e. has received treatment in the past)
Q6. For CHRONIC HEPATIT regimens as well as the resp	•	•	d, please list all previous treatment lapser, etc):
Q7. For CHRONIC HEPATITIS	C, will Pegasys be used i	in conjunction with	Sovaldi?
☐ Yes		□No	
Q8. If the patient's diagnosis is	OTHER, please specify b	elow:	



Pegasys-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
Q9. Does the patient have any of the following? (please s	elect all that apply):
☐ Decompensated liver disease☐ Autoimmune hepatitis	
Concomitant administration of didanosine with riba	virin in patients co-infected with HIV
☐ None of the above	
Q10. Please select the prescriber's specialty:	
☐ Infectious disease (ID)	
Gastroenterology	
☐ Oncology ☐ Other	
_	h ala
Q11. If the prescriber specialty is Other, please describe	below:
Q12. Will the patient be monitored for evidence of depres	sion?
☐Yes	□No
Q13. Please indicate the patient's age below:	
☐ 0 to 2 years	
3 - 4 years old	
5-17 years	
☐ 18 years old or older	
Prescriber Signature	Date



Pigray-12 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
		Dharras
Member/Subscriber Number: Date of Birth:	Fax: Office Contact:	Phone:
Group Number:	NPI:	State Lic ID:
Address:	Address:	State Lie ib.
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name ((if applicable):
*Please note that Envision will process the request	as written, including drug	name, with no substitution.
	☐ Expedited/Urg	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or inform	nation for this patient that ma	ay support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing th	erapy
Q2. For CONTINUING THERAPY, please provide	the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the re	quested medication:	
☐ Breast cancer, advanced or metastatic	☐ Other	
Q4. If the patient's diagnosis is OTHER, please sp	pecify below:	
Q5. Is the patient's disease hormone receptor (HR)-negative?	positive, and human epidern	nal growth factor receptor 2 (HER2)-
☐ Yes	☐ No	
Q6. Is the patient's cancer PIK3CA-mutated?		
☐ Yes	□No	
Q7. Please select all that apply to this patient:		
☐ The patient is a male or postmenopausal wom	nan	
☐ The requested medication will be used in com	bination with fulvestrant	
☐ The patient's disease has progressed on or af	ter an endocrine-based regi	men



Piqray-12 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
☐ None of the above	
Q8. Is the patient 18 years of age or older?	
Yes	□No
Q9. Is the requested medication prescribed by (or in cons	ultation with) an oncologist?
☐Yes	□No
Prescriber Signature	Date



Pomalyst-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if	f applicable):
*Please note that Envision will process the request as	written, including drug	name, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informatio following qu	on for this patient that may uestions and sign.	/ support approval. Please answer the
Q1. Is the request for initial or continuing therapy?		
│	☐ Continuing the	erapy
Q2. For continuing therapy, please specify start date (MM/YY):	
Q3. Please indicate the patient's diagnosis below:		
☐ Multiple myeloma, in combination with dexamethas	sone	
Q4. If the patient's diagnosis is OTHER, please specif	y below.	
Q5. Please select all that apply to this patient:		
☐ Patient has received at least two (2) prior therapie	s including lenalidomide	(Revlimid) and a proteasome inhibitor
(bortezomib (Velcade))		
☐ Disease has progressed within 60 days of completion of the last therapy		
☐ Patient has been counseled about the use of reliable contraception before, during and 1 month after initiation of		
therapy		
Patient has been assessed to determine if prophylactic aspirin or antithrombotic treatment (warfarin, clopidogrel)		
will need to be taken to reduce the risk of VTE (embolist	, , , , , , , , , , , , , , , , , , ,	ok Evaluation and Mitigation Strategy
Patient is registered and certified to be compliant with Pomalyst REMS (Risk Evaluation and Mitigation Strategy)		
program None of the above		



Pomalyst-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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.

Dations No.	Para author Name
Patient Name:	Prescriber Name:
Q6. For FEMALES OF CHILD-BEARING POTENTIAL, p	lease select all that apply:
 ☐ Two (2) negative pregnancy tests have been obtai ☐ Patient will receive pregnancy test monthly during ☐ Patient is male or not of reproductive potential ☐ None of the above 	•
Q7. Please indicate the prescriber's specialty below:	
☐ Oncologist ☐ Hematolog	gist Other
Q8. If the answer is OTHER, please specify:	
Power than O'constant	
Prescriber Signature	Date



Promacta-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicabl	e):
*Please note that Envision will process the request as v	vritten, including drug name, w	ith no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informatio	n for this patient that may support	approval. Please answer the
	uestions and sign.	арр готан годос аноног инс
O1 to required for initial or continuing the require		
Q1. Is request for initial or continuing therapy?	_	
Initial therapy	Continuing therapy	
Q2. For continuing therapy, please specify start date (MM/YY):		
3	,	
Q3. Please indicate the diagnosis for which the requester	d medication is being prescribed:	
Idiopathic thrombocytopenic purpura (ITP)	a medication to being precented.	
Hepatitis C infection associated thrombocytopenia		
Severe aplastic anemia with insufficient response	to immunosuppressive therapy or	in combination with
immunosuppressive therapy		m combination man
☐ Other		
O4 If the nationt's diagnosis is OTHED places encein	, holow:	
Q4. If the patient's diagnosis is OTHER, please specify	y below.	
Q5. Has the patient had an insufficient response or intole	rance to corticosteroids, immuno	globulins, or splenectomy?
☐ Yes	☐ No	
Q6. Is the platelet (Plt) count at time of diagnosis: less the	an 30,000/mcL OR less than or e	gual to 50,000/mcL with
significant mucous membrane bleeding or risk factors for		•
Yes	□ No	
	□··•	



Promacta-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:	
Q7. Will liver function be assessed pretreatment and regularly throughout therapy?		
Yes	□ No	
Q8. Are alanine aminotransferase levels greater than or effollowing characteristics: progressive, persistent, accompevidence of hepatic decompensation?	equal to 3 times the upper limit of normal with any of the panied by increased bilirubin or symptoms of liver injury or	
Yes	□ No	
Q9. For CONTINUING therapy: Has the platelet count rehas increased to at least 50,000/mcL)	sponded to Promacta? (Response defined as: Platelet count	
☐ Yes	□ No	
	count less than 50,000/microliter: Has platelet count increased g after at least 4 weeks of Promacta at the maximum dose?	
☐ Yes	□No	
Q11. For CONTINUING therapy: If platelet counts rise ab	oove 200,000/mcL with Promacta, will therapy be adjusted to s risk for bleeding?	
☐ Yes	□ No	
Prescriber Signature	 Date	



Regranex-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if	applicable):
Please note that Envision will process the	request as written, including drug	name, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history		support approval. Please answer the
Please attach any pertinent medical history	or information for this patient that may following questions and sign.	support approval. Please answer the
Please attach any pertinent medical history		support approval. Please answer the
Please attach any pertinent medical history Q1. Is this request for initial or continuing the	following questions and sign.	support approval. Please answer the
	following questions and sign.	
Q1. Is this request for initial or continuing th	following questions and sign. erapy? Continuing the	
Q1. Is this request for initial or continuing the	following questions and sign. erapy? Continuing the	
Q1. Is this request for initial or continuing th	erapy? Continuing the e indicate the start date (MM/YY):	
Q1. Is this request for initial or continuing the limitial therapy Q2. For CONTINUING THERAPY, please	erapy? Continuing the e indicate the start date (MM/YY):	
Q1. Is this request for initial or continuing the Initial therapy Q2. For CONTINUING THERAPY, please Q3. Please indicate the patient's diagnosis for Initial therapy	erapy? Continuing the e indicate the start date (MM/YY): for the requested medication below:	
Q1. Is this request for initial or continuing the Initial therapy Q2. For CONTINUING THERAPY, please Q3. Please indicate the patient's diagnosis for the patient's diagno	erapy? Continuing the e indicate the start date (MM/YY): for the requested medication below:	
Q1. Is this request for initial or continuing the Initial therapy Q2. For CONTINUING THERAPY, please Q3. Please indicate the patient's diagnosis for Initial therapy	erapy? Continuing the e indicate the start date (MM/YY): for the requested medication below: Other	rapy



Regranex-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Na	me:
	·	
Prescriber Signature		 Date



Revlimid-7 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (i	if applicable):
*Please note that Envision will process the reques	t as written, including drug	name, with no substitution.
	☐ Expedited/Urg	ent
Drug Name and Strength:		
Directions / CIC.		
Directions / SIG:		
Please attach any pertinent medical history or infor		y support approval. Please answer the
follow	ing questions and sign.	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	erapy
Q2. For CONTINUING THERAPY please indicate the start date (MM/YY):		
·	,	
Q3. Please indicate the patient's diagnosis for the re	equested medication: *	
Follicular lymphoma		
☐ Mantle cell lymphoma		
☐ Marginal zone lymphoma		
☐ Multiple Myeloma		
☐ Transfusion-dependent anemia		
☐ Other		
Q4. For MANTLE CELL LYMPHOMA, has the pa (one of which included bortezomib)?	ntient's disease relapsed or pr	rogressed after two (2) prior therapies
Yes	□No	
Q5. For MULTIPLE MYELOMA, please indicate I	now the requested medication	will be used in this patient:
As maintenance therapy following autolog	ous stem cell transplant	
☐ In combination with dexamethasone		
☐ None of the above		



Revlimid-7 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:	
Q6. For TRANSFUSION-DEPENDENT ANEMIA, is the syndromes associated with a deletion 5q cytogenetic a abnormalities?	e condition due to low- or intermediate-1-risk myelodysplastic abnormality with or without additional cytogenetic	
☐Yes	□ No	
Q7. If the patient's diagnosis is OTHER, please specify	/ below:	
Q8. For FOLLICULAR LYMPHOMA or MARGINAL ZONE The patient's disease has been previously treated The requested medication will be used in combinate None of the above	E LYMPHOMA, please select all that apply to this patient:	
Q9. Is the patient enrolled in the Revlimid REMS Progran	n?	
☐Yes	□ No	
Q10. Is the patient pregnant?		
☐ Yes	□ No	
Q11. Have male and female patients of child-bearing pote appropriate contraceptive methods for Revlimid use?	ential been instructed on the importance of proper utilization of	
☐ Yes	□ No	
Q12. Will the patient be monitored for signs and symptoms of thromboembolism?		
☐ Yes	□ No	
Prescriber Signature		



COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Rozlytrek-12 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if a	applicable):
*Please note that Envision will process th	ne request as written, including drug n	ame, with no substitution.
	☐ Expedited/Urger	nt
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical histo	ry or information for this patient that may following questions and sign.	support approval. Please answer the
	Tollowing questions and sign.	
Q1. Is this request for initial or continuing t	therapy?	
☐ Initial therapy	☐ Continuing there	ару
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):		
Q3. Please indicate the patient's diagnosis	s for the requested medication:	
☐ ROS1-positive metastatic non-smal	l cell lung cancer (NSCLC)	
	nic tyrosine receptor kinase (NTRK) gene	fusion without a known acquired
resistance mutation		
Other		
Q4. If the patient's diagnosis is OTHER	, please specify below.	
Q5. For Solid tumors: Please check all tha	ut apply:	
	e surgical resection is likely to result in s	evere morbidity
_	d following treatment or have no satisfact	•
☐ None of the above		.,
Q6. Is the requested medication prescribe	d by, or in consultation with, an oncologi	st?
☐ Yes		
	∐ NO	



COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Rozlytrek-12 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:	
Prescriber Signature	 Date	



Rubraca-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):
*Please note that Envision will process the request as v	vritten, including drug	name, with no substitution.
	☐ Expedited/Urg	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that ma estions and sign.	y support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	erapy
Q2. For CONTINUING THERAPY, please provide the	start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the reques	ted medication:	
☐ Epithelial ovarian, fallopian tube, or primary periton mutation associated)	eal cancer (deleterious	germline and/or somatic BRCA
☐ Epithelial ovarian, fallopian tube, or primary periton☐ Other	eal cancer (recurrent)	
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Is the patient 18 years of age or older?		
☐ Yes	☐ No	
Q6. Is Rubraca being prescribed by a hematologist or one	cologist?	
☐ Yes	☐ No	
Q7. Please select all that apply to this patient:		
☐ The patient is BRCA mutation positive as detected	by an approved FDA la	boratory test



Rubraca-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:		
☐ The patient has had previous trial and failure with two or more chemotherapy regimens ☐ The patient has had a complete or partial response to platinum-based chemotherapy ☐ Rubraca will be used as monotherapy ☐ The provider agrees to perform a complete blood count (CBC) at baseline and monthly thereafter ☐ None of the above			
Q8. For WOMEN OF REPRODUCTIVE POTENTIAL, will an effective method of contraception be used during therapy and for 6 months after the last dose? Yes No No N/A - The patient is not a female of reproductive potential			
Prescriber Signature	 Date		



Rydapt-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Deficient Names	Dung a wilh a w Name a	
Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name	(if applicable):
*Please note that Envision will process the request as	written, including drug	g name, with no substitution.
	☐ Expedited/Urg	gent
Drug Name and Strength:		
Directions / SIG:		
Discount de la constant de la consta		
Please attach any pertinent medical history or informati following	ion for this patient that ma questions and sign.	ay support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing th	nerapy
Q2. If the request is for CONTINUING THERAPY, ple	ease provide the start da	te (MM/YY):
Q3. Please indicate the patient's diagnosis for the reque	ested medication:	
Acute myeloid leukemia (AML), newly diagnosed		
☐ Mast cell leukemia (MCL)		
Systemic mastocytosis		
Other		
OA FOR ACUTE MYELOID LEUKEMIA Places soles	turbish of the following (i	f and annual to this nations.
Q4. For ACUTE MYELOID LEUKEMIA, please selec	t which of the following (i	rany) apply to this patient:
☐ The patient is treatment naïve		
The patient is FLT3 mutation-positive		
Rydapt will be used in combination with stand	lard cytarabine and daun	orubicin induction and cytarabine
consolidation chemotherapy		
☐ None of the above		
Q5. If the patient's diagnosis is OTHER, please spec	ify below:	
Q6. Is the patient 18 years of age or older?		
Qo. 10 the patient to years of age of older:		



Rydapt-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
☐ Yes	□No
Q7. Is the requested medication being prescribed by (or i	in consultation with) an oncologist?
☐Yes	□ No
Q8. Does the patient have angioedema?	
☐Yes	□ No
Prescriber Signature	Date



Samsca-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicab	le):
*Please note that Envision will process the request as v	vritten, including drug name, v	vith no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
D: 11 / 100		
Directions / SIG:		
Please attach any pertinent medical history or information	n for this patient that may suppor	t approval. Please answer the
	estions and sign.	••
Q1. Is the request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For continuing therapy, please specify start date (MM/YY):		
	,	
Q3. Please indicate the patient's diagnosis for the reques	ted medication:	
☐ Hypervolemic hyponatremia		
☐ Euvolemic hyponatremia		
Other		
_		
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Does the patient have anuria?		
☐ Yes	☐ No	
Q6. Does the patient require an URGENT increase in ser	um sodium?	
☐ Yes	□No	
Q7. Is the patient able to sense and respond to thirst?		
☐ Yes	□No	



Samsca-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:	
Q8. Will Samsca be used in combination wit	th a strong CYP3A inhibitor (such as clarithromycin or ketocona	ızole)?
☐ Yes	□No	
Q9. Will Samsca be initiated or re-initiated in	n a hospital where serum sodium can be monitored closely?	
☐ Yes	□No	
Prescriber Signature	Date	



Sildenafil-5 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable)):
*Please note that Envision will process the request as w	ritten, including drug name, wit	h no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information	for this natient that may support a	nnroval Please answer the
	estions and sign.	pprovail ricuse answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For continuing therapy, please specify start date (M	IM/YY):	
Q3. Please indicate the patient's diagnosis for the request	red medication:	
☐ Pulmonary arterial hypertension (PAH) (WHO Group	o I)	
	· .	
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Has PAH been confirmed by right heart catheterization undergo a right heart catheterization (e.g., patient is frail, e.g.,	,	patient is unable to
☐Yes	□ No	
Q6. Is the patient currently on nitrate therapy?		
☐ Yes	□No	



Sildenafil-5 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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: Prescriber Name:** Prescriber Signature Date



Somatuline-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone: Specialty/facility name (if applicable):		
*Please note that Envision will process the request as w	vritten, including dr	ug name, with no substitution.
	☐ Expedited/U	Jrgent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information		may support approval. Please answer the
following qu	estions and sign.	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing	therapy
Q2. If the request is for CONTINUING THERAPY, plea	se provide the start of	date (MM/YY):
Q3. Please indicate the patient's diagnosis for the reques	ted medication:	
☐ Acromegaly		
Unresectable, well- or moderately-differentiated, locally advanced or metastatic carcinoid gastroenteropancreatic		
neuroendocrine tumor		
☐ Hyperthyroidism secondary to thyrotropinoma☐ Carcinoid syndrome		
Other		
Q4. If diagnosis is ACROMEGALY, please check all that apply:		
Patient has had an inadequate response to surgery and/or radiotherapy		
☐ Surgery and/or radiotherapy is not an option for this patient ☐ None of the above		
Q5. If diagnosis is OTHER, please specify.		
Q6. Is the patient 18 years of age or older?		



Prescriber Signature

EOC ID:

Somatuline-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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: Prescriber Name:** ☐ Yes ☐ No

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Date



Somavert-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	i none.
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	
*Please note that Envision will process the re	quest as written, including drug	name, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or for	information for this patient that may ollowing questions and sign.	support approval. Please answer the
· · · · · · · · · · · · · · · · · · ·		
Q1. Is this request for initial or continuing thera	apy?	
☐ Initial therapy	☐ Continuing the	rapy
Q2. If the request is for CONTINUING THEF	RAPY, please provide the start date	e (MM/YY):
Q3. Please indicate the patient's diagnosis for	the requested medication:	
☐ Acromegaly, Second-line therapy ☐ Other		
Q4. If the patient's diagnosis is OTHER, plea	ase specify below:	
Q5. Has the diagnosis of acromegaly been cor tolerance test?	nfirmed by an elevated IGF-1 level	or elevated GH level with a glucose
☐ Yes	□No	
Q6. Has the patient tried and failed a 3 month	trial of Sandostatin or Somatuline?	
☐ Yes	□No	
Q7. Is the medication being prescribed by an e	endocrinologist?	
☐ Yes	□No	
Q8. Will Somavert be administered IV?		



Somavert-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:	
☐ Yes	□ No	
Q9. Will the patient also be using Sandostatin or Somatuline while on Somavert therapy?		
☐Yes	□ No	
Q10. FOR CONTINUING THERAPY, has the patient experienced a reduction in IGF-1 level from baseline?		
☐Yes	□ No	
Prescriber Signature	Date	



Sprycel-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Better A No.		
Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):
*Please note that Envision will process the request as	s written, including drug	name, with no substitution.
	☐ Expedited/Urg	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informat	ion for this nationt that ma	y sunnort approval. Please answer the
	questions and sign.	y support approval. I lease answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy ☐ Continuing therapy		
Q2. For continuing therapy, please specify start date (MM/YY).		
and the community and apply, produce appearly count and	(
Q3. Please indicate the patient's diagnosis for the requi	ested medication: *	
		a nacitiva (Dh.L.) [navyhy diagnacad]
☐ Chronic myeloid leukemia (CML) in chronic phase,☐ Chronic myeloid leukemia (CML) in chronic, accele	•	. , , , , , , , , , , , , , , , , , , ,
chromosome-positive (Ph+)	rated, myelold or lymphor	u biast priase, Frillauelprila
Acute lymphoblastic leukemia (ALL), Philadelphia o	chromosome-positive (Ph-	+)
☐ Newly diagnosed Ph+ Acute lymphoblastic leukemi	• `	,
Other	a (ALL) in combination wi	an enome area apy
Q4. If the patient's diagnosis is OTHER, please spec	city below:	
Q5. Has the patient had resistance or intolerance to pri-	or therapy?	
☐ Yes	☐ No	
Q6. If yes, did the prior therapy include imatinib (Gleen	evec)?	
Yes	□ No	
□ 1 €2		



Sprycel-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
Q7. Is the medication being prescribed by an oncologist?	
☐Yes	□ No
Prescriber Signature	 Date



Stivarga-5 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:		
Member/Subscriber Number:	Fax:	Phone:	
Date of Birth:	Office Contact:	00.00.00	
Group Number:	NPI:	State Lic ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Primary Phone:	Specialty/facility name (if applicable):		
*Please note that Envision will process the	request as written, including drug i	name, with no substitution.	
	☐ Expedited/Urge	nt	
Drug Name and Strength:			
Directions / SIG:			
Directions / Sig.			
Please attach any pertinent medical history	or information for this nationt that may	sunnort approval Please answer the	
r lease attach any pertinent medical history	following questions and sign.	support approval. I lease allower the	
Q1. Is this request for initial or continuing the	erapy?		
☐ Initial therapy	☐ Continuing the	rapy	
Q2. For continuing therapy, please specify	y start date (IVIIVI/YY).		
Q3. Please indicate the patient's diagnosis for	or the requested medication:		
☐ Colorectal cancer (metastatic)			
☐ Gastrointestinal stromal tumors (GIST) (locally advanced, unresectable or met	tastatic)	
☐ Hepatocellular carcinoma (previously tre	ated with sorafenib [Nexavar])		
☐ Other			
Q4. For COLORECTAL CANCER, is the	patient's disease KRAS mutation nega	ative?	
Yes	□ No		
Q5. For COLORECTAL CANCER, please select all that apply):	indicate which of the following the pa	tient has previously tried (please	
☐ Fluoropyrimidine-, oxaliplatin, and ☐ Bevacizumab (Avastin)	irinotecan-based chemotherapy		
☐ Panitumumab (Vectibix)			
Cetuximab (Erbitux)			
Other			



Stivarga-5 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
Q6. If medication is Other, please specify:	
O7 For GASTPOINTESTINAL STROMAL TUMORS	please select which of the following the patient has previously
tried (please select all that apply):	please select which of the following the patient has previously
☐ Imatinib mesylate (Gleevec)	
☐ Sunitinib malate (Sutent) ☐ Other	
Q8. If OTHER, please specify:	
Q9. If the patient's diagnosis is OTHER, please specify	/ below:
Q10. Is the patient 18 years of age or older?	
☐ Yes	□ No
Q11. Is the requested medication being prescribed by an	oncologist?
☐ Yes	□ No
Prescriber Signature	 Date



Sutent-4 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applica	ble):
*Please note that Envision will process the request as v	vritten, including drug name,	with no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information	n for this nationt that may sunno	rt annroval Please answer the
	estions and sign.	it approval. I lease allower the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy ☐ Continuing therapy		
Q2. If the request is for CONTINUING THERAPY, plea	ase provide the start date (MM/Y	Y):
,		,
Q3. Please indicate the patient's diagnosis below: *		
☐ Progressive, well-differentiated pancreatic neuroendo	ocrine tumors in a patient with ur	nresectable locally advanced or
metastatic disease		
Renal cell carcinoma, advanced/metastatic		
Gastrointestinal stromal tumor		
Adjuvant treatment in renal cell carcinoma for patients at high risk of recurrence following nephrectomy		
Other		
Q4. If the diagnosis is OTHER, please specify.		
Q5. For GASTROINTESTINAL STROMAL TUMORS, has	s the patient had disease progre	ession on or intolerance to
Gleevec (imatinib)?	a the patient had alleged progre	
Yes	□No	
Q6. Is the patient 18 years of age or older?		
☐ Yes	□ No	
I .		



Sutent-4 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:	
Q7. Is the medication prescribed by an oncologist?		
☐ Yes	□ No	
Prescriber Signature	Date	



Sylatron-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applic	:able):
*Please note that Envision will process the request as v	vritten, including drug name	, with no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informatio	n for this patient that may supp lestions and sign.	ort approval. Please answer the
Tonormia 40		_
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	Continuing therapy	
Q2. If the request is for CONTINUING THERAPY, plea	ase provide the start date (MM/	
Q3. Please indicate the patient's diagnosis below:		
☐ Malignant Melanoma with microscopic or gross nod	lal	
involvement	☐ Other	
Q4. If the diagnosis is OTHER, please specify:		
Q5. Does the patient have any of the following (please se	elect all that apply)?	
☐ Autoimmune hepatitis		
☐ Hepatic decompensation (Child-Pugh score greate	r than 6 [Class B or C])	
☐ None of the above		
Q6. For melanoma with microscopic or gross nodal involv	vement is Sylatron heing used	as adjuvant treatment within
84 days of definitive surgical resection, including complet	•	as adjuvant treatment within
Yes	□ No	



Sylatron-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:	
Prescriber Signature	 Date	



Symdeko-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Date of Birth: Group Number: Address: Address: Address: Address: City, State ZIP: Primary Phone: Please note that Envision will process the request as written, including drug name, with no substitution. Please note that Envision will process the request as written, including drug name, with no substitution. Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign. Q1. Is this request for initial or continuing therapy? Initial therapy Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY): Q3. Please indicate the patient's diagnosis for the requested medication: Cystic fibrosis Q4. If the patient's diagnosis is OTHER, please specify below: Q5. Please select if any of the following apply to this patient: The patient has a mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to tezacaftor/ivacaftor verified by a FDA-approved CF mutation test NPI: State Lic ID: Address: City, State ZIP: Specialty/facility name (if applicable): Expedited/Urgent Expedited/Urgent Capped The patient is for substitution. Continuing therapy Continuing therapy Continuing therapy Q6. If the patient is homozygous for the F508del mutation The patient has a mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to tezacaftor/ivacaftor verified by a FDA-approved CF mutation test Q6. Is the patient 6 years of age or older?	Patient Name:	Prescriber Name:	
Address: Address: City, State ZIP: City, State ZIP: Specialty/facility name (if applicable): **Please note that Envision will process the request as written, including drug name, with no substitution. Expedited/Urgent	Member/Subscriber Number:	Fax:	Phone:
Address: City, State ZIP: City, State ZIP: Specialty/facility name (if applicable): Please note that Envision will process the request as written, including drug name, with no substitution. City Name and Strength: City State ZIP: Specialty/facility name (if applicable): Please note that Envision will process the request as written, including drug name, with no substitution. Expedited/Urgent City State ZIP: Expedited/Urgent City State ZIP: Expedited/Urgent Expedited/Urgent Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign. Q1. Is this request for initial or continuing therapy? Continuing therapy Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY): Q3. Please indicate the patient's diagnosis for the requested medication: Cystic fibrosis Q4. If the patient's diagnosis is OTHER, please specify below: Q5. Please select if any of the following apply to this patient: The patient is homozygous for the F508del mutation The patient has a mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to tezacaftor/ivacaftor verified by a FDA-approved CF mutation test None of the above Q6. Is the patient 6 years of age or older?	Date of Birth:	Office Contact:	
City, State ZIP: Primary Phone: Please note that Envision will process the request as written, including drug name, with no substitution. Expedited/Urgent	Group Number:	NPI:	State Lic ID:
Primary Phone: Specialty/facility name (if applicable): Please note that Envision will process the request as written, including drug name, with no substitution. Expedited/Urgent Drug Name and Strength: Directions / SIG: Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign. Q1. Is this request for initial or continuing therapy? Initial therapy	Address:	Address:	
Please note that Envision will process the request as written, including drug name, with no substitution. Expedited/Urgent		_	
Drug Name and Strength: Directions / SIG: Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign. Q1. Is this request for initial or continuing therapy? Initial therapy	Primary Phone:	Specialty/facility name (if	f applicable):
Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign. Q1. Is this request for initial or continuing therapy? Initial therapy	Please note that Envision will process the i	equest as written, including drug	name, with no substitution.
Q1. Is this request for initial or continuing therapy? Initial therapy		☐ Expedited/Urge	ent
Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign. Q1. Is this request for initial or continuing therapy? Initial therapy	Orug Name and Strength:		
Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign. Q1. Is this request for initial or continuing therapy? Initial therapy	Directions / SIG:		
Q1. Is this request for initial or continuing therapy? Initial therapy			
Q1. Is this request for initial or continuing therapy? Initial therapy	Please attach any pertinent medical history of		support approval. Please answer the
□ Initial therapy □ Continuing therapy Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY): Q3. Please indicate the patient's diagnosis for the requested medication: □ Cystic fibrosis □ Other Q4. If the patient's diagnosis is OTHER, please specify below: Q5. Please select if any of the following apply to this patient: □ The patient is homozygous for the F508del mutation □ The patient has a mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to tezacaftor/ivacaftor verified by a FDA-approved CF mutation test □ None of the above Q6. Is the patient 6 years of age or older?		following questions and sign.	
□ Initial therapy □ Continuing therapy Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY): Q3. Please indicate the patient's diagnosis for the requested medication: □ Cystic fibrosis □ Other Q4. If the patient's diagnosis is OTHER, please specify below: Q5. Please select if any of the following apply to this patient: □ The patient is homozygous for the F508del mutation □ The patient has a mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to tezacaftor/ivacaftor verified by a FDA-approved CF mutation test □ None of the above Q6. Is the patient 6 years of age or older?			
Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY): Q3. Please indicate the patient's diagnosis for the requested medication: Cystic fibrosis Q4. If the patient's diagnosis is OTHER, please specify below: Q5. Please select if any of the following apply to this patient: The patient is homozygous for the F508del mutation The patient has a mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to tezacaftor/ivacaftor verified by a FDA-approved CF mutation test None of the above Q6. Is the patient 6 years of age or older?	Q1. Is this request for initial or continuing the	rapy?	
Q3. Please indicate the patient's diagnosis for the requested medication: Cystic fibrosis Other Q4. If the patient's diagnosis is OTHER, please specify below: Q5. Please select if any of the following apply to this patient: The patient is homozygous for the F508del mutation The patient has a mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to tezacaftor/ivacaftor verified by a FDA-approved CF mutation test None of the above Q6. Is the patient 6 years of age or older?	☐ Initial therapy	☐ Continuing the	rapy
Q3. Please indicate the patient's diagnosis for the requested medication: Cystic fibrosis Q4. If the patient's diagnosis is OTHER, please specify below: Q5. Please select if any of the following apply to this patient: The patient is homozygous for the F508del mutation The patient has a mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to tezacaftor/ivacaftor verified by a FDA-approved CF mutation test None of the above Q6. Is the patient 6 years of age or older?	O2 If the request is for CONTINUING THE	 FRAPY_nlease provide the start date	2 (MM/YY).
☐ Cystic fibrosis ☐ Other Q4. If the patient's diagnosis is OTHER, please specify below: Q5. Please select if any of the following apply to this patient: ☐ The patient is homozygous for the F508del mutation ☐ The patient has a mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to tezacaftor/ivacaftor verified by a FDA-approved CF mutation test ☐ None of the above Q6. Is the patient 6 years of age or older?	Q2. If the request is for Gentring into This	21VII 1, picase provide the start date	. (WIWI 1 1).
☐ Cystic fibrosis ☐ Other Q4. If the patient's diagnosis is OTHER, please specify below: Q5. Please select if any of the following apply to this patient: ☐ The patient is homozygous for the F508del mutation ☐ The patient has a mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to tezacaftor/ivacaftor verified by a FDA-approved CF mutation test ☐ None of the above Q6. Is the patient 6 years of age or older?	O3 Please indicate the patient's diagnosis fo	or the requested medication:	
Q4. If the patient's diagnosis is OTHER, please specify below: Q5. Please select if any of the following apply to this patient: The patient is homozygous for the F508del mutation The patient has a mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to tezacaftor/ivacaftor verified by a FDA-approved CF mutation test None of the above Q6. Is the patient 6 years of age or older?			
Q5. Please select if any of the following apply to this patient: The patient is homozygous for the F508del mutation The patient has a mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to tezacaftor/ivacaftor verified by a FDA-approved CF mutation test None of the above Q6. Is the patient 6 years of age or older?	Cystic librosis		
☐ The patient is homozygous for the F508del mutation ☐ The patient has a mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to tezacaftor/ivacaftor verified by a FDA-approved CF mutation test ☐ None of the above Q6. Is the patient 6 years of age or older?	Q4. If the patient's diagnosis is OTHER, pl	ease specify below:	
☐ The patient is homozygous for the F508del mutation ☐ The patient has a mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to tezacaftor/ivacaftor verified by a FDA-approved CF mutation test ☐ None of the above Q6. Is the patient 6 years of age or older?			
☐ The patient has a mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to tezacaftor/ivacaftor verified by a FDA-approved CF mutation test ☐ None of the above Q6. Is the patient 6 years of age or older?	Q5. Please select if any of the following apply	y to this patient:	
responsive to tezacaftor/ivacaftor verified by a FDA-approved CF mutation test None of the above Q6. Is the patient 6 years of age or older?		8del mutation	
Q6. Is the patient 6 years of age or older?	│	c fibrosis transmembrane conductan	ce regulator (CFTR) gene that is
Q6. Is the patient 6 years of age or older?			
	☐ The patient has a mutation in the cysti		
	☐ The patient has a mutation in the cystic responsive to tezacaftor/ivacaftor verified by		
│	☐ The patient has a mutation in the cystic responsive to tezacaftor/ivacaftor verified by ☐ None of the above		



Symdeko-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
Prescriber Signature	Date



Symlin-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	FIIOHE.
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if	applicable):
*Please note that Envision will process the request as v	written, including drug i	name, with no substitution.
	☐ Expedited/Urge	nt
Drug Name and Strength:		
Directions / SIG:		
Directions / Sig.		
Please attach any pertinent medical history or informatio following qu	n for this patient that may uestions and sign.	support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	Continuing the	rapy
Q2. For INITIAL THERAPY, does the patient have inac 9%)?	dequate glycemic control	(HbA1c greater than 7% but less than
☐Yes	☐ No	
Q3. For CONTINUING THERAPY, please indicate the	start date (MM/YY):	
Q4. For CONTINUING THERAPY, has the patient taken reduction in HbA1c since initiating Symlin therapy?	Symlin in the previous 6	months and demonstrated a
☐ Yes	□No	
Q5. Please indicate the patient's diagnosis for the reques	sted medication:	
☐ Diabetes mellitus (type 1 or type 2), adjunctive treatment	☐ Other	
Q6. If the patient's diagnosis is OTHER, please specify	y below:	
Q7. Is the patient currently receiving optimal mealtime in	sulin therapy?	
☐ Yes	□ No	



Symlin-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
Q8. Does the patient have any of the following exclusions	(please select all that apply)?
 ☐ Gastroparesis ☐ Hypoglycemia unawareness (i.e. inability to detect ☐ Severe hypoglycemia that required assistance duri ☐ The patient requires drug therapy to stimulate gast ☐ None of the above 	-
Prescriber Signature	



Tafinlar-6 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (it	f applicable):
*Please note that Envision will process the red	quest as written, including drug	name, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or fo	information for this patient that may ollowing questions and sign.	/ support approval. Please answer the
Q1. Is this request for initial or continuing thera	py?	
☐ Initial therapy	☐ Continuing the	erapy
Q2. If the request is for CONTINUING THER	RAPY, please provide the start date	e (MM/YY):
Q3. Please indicate the patient's diagnosis for t	the requested medication:	
☐ Melanoma (unresectable or metastatic) in a patient with BRAF V600E mutation (single agent therapy) ☐ Melanoma (unresectable or metastatic) in patients with BRAF V600E or V600K mutation (in combination with trametinib [Mekinist])		
☐ Non-small cell lung cancer, Metastatic with BRAF V600E mutation, in combination with trametinib		
☐ Anaplastic thyroid carcinoma, Locally advanced or metastatic, with BRAF V600E mutation, in combination with trametinib☐ Other		
Outer		
Q4. If the patient's diagnosis is OTHER, plea	ase specify below:	
Q5. Does the patient have a positive BRAF V6	00E or V600K mutation as detecte	d by an FDA-approved test?
☐ Yes	□ No	
Q6. Does the patient have wild-type BRAF mel	anoma?	
☐ Yes	☐ No	



Prescriber Signature

EOC ID:

Tafinlar-6 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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: Prescriber Name:** Q7. Is the requested medication being prescribed by an oncologist? ☐ Yes

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Date



Tagrisso-4 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name	(if applicable):
*Please note that Envision will process the request as	written, including dru	g name, with no substitution.
	☐ Expedited/Ur	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informatio	on for this patient that muestions and sign.	ay support approval. Please answer the
Tonowing q	uconono una oigii.	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy ☐ Continuing therapy		
Q2. If the request is for CONTINUING THERAPY, plea	ase provide the start da	ate (MM/YY):
	•	,
Q3. Please indicate the patient's diagnosis for the reques	sted medication:	
☐ Non-small cell lung cancer (NSCLC), metastatic	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specif	y below:	
Q5. Was the patient's diagnosis confirmed by an FDA-ap	onroved test?	
Yes	☐ No	
Q6. Please select if any of the following apply to this pati	ent:	
☐ The disease is metastatic EGFR mutation-positive		
☐ There is confirmed presence of T790M EGFR tum		
☐ The patient's disease has progressed on or after E		nhibitor based therapy
☐ None of the above		
I		



Prescriber Signature

Fax back to: 877-503-7231

Date

EOC ID:

Phone: 800-361-4542

Tagrisso-4 Medicare

Rx 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: Prescriber Name:**



Takhzyro-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if	applicable):
Please note that Envision will process the reques	st as written, including drug i	name, with no substitution.
	☐ Expedited/Urge	nt
Drug Name and Strength:		
2		
Directions / SIG:		
Please attach any pertinent medical history or info	mation for this nationt that may	sunnert approval. Please answer the
	ring questions and sign.	support approval. Flease allswer tile
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	rapy
	he start date (MM/YY)·	
Q2. For CONTINUING THERAPY, please provide t		
Q2. For CONTINUING THERAPY, please provide t	ino start dato (MM) 11).	
Q3. Please indicate the patient's diagnosis for the r	equested medication:	
Q3. Please indicate the patient's diagnosis for the r	equested medication:	
Q3. Please indicate the patient's diagnosis for the r Hereditary angioedema (prophylaxis)	equested medication:	
Q3. Please indicate the patient's diagnosis for the r Hereditary angioedema (prophylaxis)	equested medication:	
Q3. Please indicate the patient's diagnosis for the r Hereditary angioedema (prophylaxis) Q4. If the patient's diagnosis is OTHER, please spe	equested medication:	



Takhzyro-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
Prescriber Signature	Date



Talzenna-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (i	f applicable):
*Please note that Envision will process the request as	written, including drug	name, with no substitution.
☐ Expedited/Urgent		
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informati	ion for this natient that ma	v support approval. Please answer the
	questions and sign.	y support approval. I least answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	erapy
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):		
Q2.1 of CONTINUING THE VIII 1, please provide and	o otali dato (www.iii).	
Q3. Please indicate the patient's diagnosis for the reque	ested medication:	
☐ Breast cancer (locally advanced or metastatic)	☐ Other	
Q4. If the patient's diagnosis is OTHER, please spec	ify below:	
Q5. Does the patient have presence of a deleterious or	suspected deleterious ge	rmline BRCA-mutation (gBRCAm)?
☐ Yes	□ No	(92107111)
L Tes		
Q6. Is the patient's disease human epidermal growth fa	ctor receptor 2 (HER2)-ne	egative?
☐ Yes	☐ No	
Q7. Is the requested medication prescribed by (or in co	nsultation with) an oncolo	gist?
☐ Yes	☐ No	
Q8. Is the patient 18 years of age or older?		



Prescriber Signature

EOC ID:

Talzenna-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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: Prescriber Name:** ☐ Yes ☐ No

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Date



Tasigna-5 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:		
Member/Subscriber Number:	Fax:	Phone:	
Date of Birth:	Office Contact:	0	
Group Number:	NPI:	State Lic ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:	<i></i>	
Primary Phone:	Specialty/facility name (if applicable):		
*Please note that Envision will process the request as	written, including drug	name, with no substitution.	
	☐ Expedited/Urg	jent	
Drug Name and Strength:			
Directions / SIG:			
Please attach any pertinent medical history or informati following or	ion for this patient that ma questions and sign.	y support approval. Please answer the	
Q1. Is this request for initial or continuing therapy?			
☐ Initial therapy ☐ Continuing therapy			
☐ IIIIII піва піетару		егару	
Q2. If the request is for CONTINUING THERAPY, ple	ease provide the start dat	te (MM/YY):	
Q3. Please indicate the patient's diagnosis for the reque	ested medication: *		
☐ Philadelphia chromosome positive chronic myeloid		hronic phase (newly diagnosed)	
Chronic phase (CP) and accelerated phase (AP) Ph	, ,	monic phase (newly diagnosed)	
Other	T' GIVIL		
Q4. Is the patient resistant to or intolerant to prior the	rapy ?		
☐ Yes	☐ No		
OF If the neticution diamensis is OTHER places and	:£.		
Q5. If the patient's diagnosis is OTHER, please speci	ity below:		
Q6. Is the requested medication being prescribed by an	oncologist?		
☐Yes	☐ No		



Tasigna-5 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:	
Prescriber Signature	Date	



Tegsedi-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):
*Please note that Envision will process the request as	written, including drug	name, with no substitution.
	☐ Expedited/Urg	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following q	on for this patient that ma uestions and sign.	y support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing th	erapy
Q2. For CONTINUING THERAPY, please specify the	start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the reques	sted medication:	
☐ Polyneuropathy of hereditary transthyretin-mediated amyloidosis ☐ Other		
Q4. If the patient's diagnosis is OTHER, please specif	y below:	
Q5. Is the patient 18 years of age or older?		
☐ Yes	□No	
Q6. Is the patient enrolled in the Tegsedi REMS program	า?	
☐ Yes	□No	
Q7. Do any of the following apply to the patient (please of	check all that apply)?	
☐ Platelet count is below 100 x 10(9)/L		
☐ Documented history of acute glomerulonephritis ca	aused by inotersen	



Tegsedi-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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: Prescriber Name:** Prescriber Signature Date



Testosterone-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	. Hene.
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):
*Please note that Envision will process the request as	s written, including drug	name, with no substitution.
	☐ Expedited/Urg	ent
Drug Name and Strength:		
Directions / SIG:		
Directions / Sig.		
Please attach any pertinent medical history or informat		y support approval. Please answer the
following	questions and sign.	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy ☐ Continuing therapy		
Q2. For CONTINUING THERAPY, please indicate Start Date (MM/YY):		
q2.1 of GOTTING TIETO 11, please mailed C	tart Bato (IVIIVII 1 1).	
Q3. Please indicate the patient's diagnosis below:		
☐ Hypogonadism		
☐ Deficiency or absence of endogenous testosterone		
☐ Other		
Q4. If the patient's diagnosis is OTHER, please spec	cifv below:	
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,	
Q5. Do any of the following apply to this patient (please	select all that apply)?	
Patient is female		
☐ Patient has prostate cancer		
☐ Patient has prostate cancer		
☐ None of the above		
O6. Please indicate the natient's testosterone level PRI	OR to start of therapy:	
Q6. Please indicate the patient's testosterone level PRIOR to start of therapy:		
☐ Total testosterone GREATER than 300 ng/dL, free or bioavailable testosterone GREATER than 5 ng/dL☐ Total testosterone LESS than 300 ng/dL, free or bioavailable testosterone LESS than 5 ng/dL☐		
	TE TEMPORE TO TO TO THE	



Prescriber Signature

EOC ID:

Testosterone-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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: Prescriber Name:** Absence of endogenous testosterone ■ None of the above

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Date



Tetrabenazine-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if	applicable):
*Please note that Envision will process the request as w	vritten, including drug i	name, with no substitution.
	☐ Expedited/Urge	nt
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may lestions and sign.	support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	rapy
		.,
Q2. For continuing therapy, please specify start date (N	MM/YY):	
Q3. Please indicate the patient's diagnosis for the reques	ted medication: *	
☐ Chorea associated with Huntington disease	Other	
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Does the patient have any of the following EXCLUSIO	ONS (please select all that	at apply)?
Untreated or inadequately treated depression		
Actively suicidal		
☐ History of hepatic disease		
☐ Concurrent use of MAO inhibitors		
☐ Concurrent use of reserpine (or it has been less than 20 days since reserpine was discontinued)		
☐ None of the above		



Tetrabenazine-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:	
Prescriber Signature	Date	



Thalomid-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
	Fax:	Phone:
Date of Birth:	Office Contact:	e.ie.
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name ((if applicable):
*Please note that Envision will process the request a	ns written, including drug	name, with no substitution.
	☐ Expedited/Urg	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informa following	ntion for this patient that ma g questions and sign.	ay support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy ☐ Continuing therapy		
Q2. If the request is for CONTINUING THERAPY, p	please provide the start dat	te (MM/YY):
Q3. Please indicate the patient's diagnosis for the requ	uested medication:	
☐ Multiple myeloma, newly diagnosed		
☐ Acute treatment of the cutaneous manifestations of	of moderate to severe eryth	nema nodosum leprosum
☐ Severe erythema nodosum leprosum with cutaned	ous manifestations	· ·
☐ Other		
Q4. If the patient's diagnosis is OTHER, please spe	cify below:	
Q5. Is the requested medication being prescribed by a	an oncologist or infectious	disease specialist?
☐ Yes ☐ No		
Q6. If the diagnosis is multiple myeloma, will the patien	nt receive concurrent dexa	methasone?
☐ Yes	☐ No	
Q7. If the patient has a diagnosis of severe erythema in Thalomid be used as monotherapy?	nodosum leprosum and als	so has moderate to severe neuritis, will



Thalomid-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
☐ Yes ☐ No ☐ The patient does not have moderate to severe neuritis	S
Q8. Will the patient be monitored for signs and symptoms	of venous thromboembolism?
☐Yes	□No
Q9. Is the patient pregnant?	
☐ Yes ☐ No	☐ Not applicable
Q10. Have male and female patients of child-bearing pote appropriate contraceptive methods?	ential been instructed on the importance of proper utilization of
☐Yes	□No
Q11. Is the patient 12 years of age or older?	
☐Yes	□No
Prescriber Signature	Nate



Tibsovo-4 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if a	pplicable):
*Please note that Envision will process	the request as written, including drug na	ame, with no substitution.
	☐ Expedited/Urgen	t
Orug Name and Strength:		
Discretions / CIO		
Directions / SIG:		
Please attach any pertinent medical his	tory or information for this patient that may s	support approval. Please answer the
	following questions and sign.	••
Od la their resourcest for initial an accusting time	as the array of	
Q1. Is this request for initial or continuin		
☐ Initial therapy	Continuing thera	ару
Q2. For CONTINUING THERAPY, ple	ease provide the start date (MM/YY):	
	,	
Q3. Please indicate the patient's diagno	sis for the requested medication:	
Acute myeloid leukemia (AML), rela	·	
Acute myeloid leukemia (AML) in ne	•	
Other	my diagnosca patiente	
_	to place coloct all that apply to this pation	4.
	ts, please select all that apply to this patien	ı.
☐ The patient is 75 years of age		
	that preclude use of intensive induction che	emotherapy
☐ None of the above		
Q5. If the patient's diagnosis is OTHE	R, please specify below:	
Q6. Does the patient have a susceptible	e isocitrate dehydrogenase-1 (IDH1) mutatio	on?
☐ Yes	□No	
O7 to the requested medication in a series	and by (ar in consultation with) an arrate si	at as hamatalagist?
	ped by (or in consultation with) an oncologis	st or nematologist?



Tibsovo-4 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:	
☐Yes	□No	
Q8. Is the patient 18 years of age or older?		
Yes	□ No	
Prescriber Signature	Date	



Tracleer-6 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (i	if applicable):
Please note that Envision will process the reques	t as written, including drug	name, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions (OIO)		
Directions / SIG:		
Please attach any pertinent medical history or infor	mation for this nationt that ma	y sunnort annroyal. Please answer the
	ing questions and sign.	y support approval. I lease allower the
Г		
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	erapy
Q2. If the request is for CONTINUING THERAPY	nlease provide the start date	e (MM/YY):
	, prodoc provide and start date	· · · · · · · ·
O3 Please indicate the nationt's diagnosis for the r	oquested medication:	
Q3. Please indicate the patient's diagnosis for the re	<u></u>	
☐ Pulmonary arterial hypertension (PAH)	☐ Other	
Q4. If the patient's diagnosis is OTHER, please s	pecify below:	
Q5. Has the diagnosis of PAH been confirmed by e	ither of the following?	
Right heart catheterization	itile of the following:	
Doppler echocardiogram (if patient is unable	to underge a right heart catho	atorization)
	to undergo a right heart cathe	eterization)
☐ None of the above		
Q6. Does the patient have World Health Organization	on (WHO) Group 1 and New \	York Heart Association (NYHA)
☐Yes	☐ No	
Q7. FOR FEMALE PATIENTS OF CHILD-BEARING	G POTENTIAL has pregnand	y been excluded prior to therapy and
patient will use two forms of reliable contraception of		, 225 Oxoladed pilot to thorapy und



Tracleer-6 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
☐ Yes	
□No	
☐ N/A - patient is not a female of child-bearing potential	
Q8. Does the patient have aminotransferase elevations a injury or bilirubin at least 2 times the upper limit of normal	
☐Yes	□ No
Q9. Will the patient be receiving concomitant cyclosporine	e A or glyburide therapy?
☐Yes	□ No
Prescriber Signature	Date



Turalio-12 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	. none.
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if	applicable):
*Please note that Envision will process the r	request as written, including drug	name, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
D:(5		
Directions / SIG:		
Please attach any pertinent medical history of	or information for this patient that may following questions and sign.	support approval. Please answer the
Q1. Is this request for initial or continuing the	rapy?	
☐ Initial therapy	☐ Continuing the	rapy
Q2. For CONTINUING THERAPY, please	provide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis fo	r the requested medication:	
☐ Tenosynovial giant cell tumor	☐ Other	
Q4. If the patient's diagnosis is OTHER, pl	ease specify below:	
Q5. Please select if any of the following apply The patient is symptomatic The patient's disease is associated wit improvement with surgery None of the above	•	ations and not amenable to
Q6. Is the patient 18 years of age or older?		
☐ Yes	□No	
Q7. Is the requested medication prescribed b	y or in consultation with an oncologis	st?
☐ Yes	□No	



Prescriber Signature

EOC ID:

Turalio-12 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:

Date



Tymlos-4 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

	T		
Patient Name:	Prescriber Name:		
Member/Subscriber Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Group Number:	NPI:	State Lic ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Primary Phone:	Specialty/facility name (if applicable):		
*Please note that Envision will process the request as	written, including drug r	name, with no substitution.	
	☐ Expedited/Urger	nt	
Drug Name and Strength:			
Directions / SIG:			
Please attach any pertinent medical history or informati	on for this nationt that may	support approval. Places answer the	
	questions and sign.	support approval. I lease allower the	
Q1. Is this request for initial or continuing therapy?			
☐ Initial therapy	☐ Continuing ther	гару	
Q2. If the request is for CONTINUING THERAPY, ple	asse provide the start date	(MM/VV)-	
Q2. If the request is for CONTINUING THERM 1, pie	case provide the start date	(Wilvin 1 1).	
	atad a district		
Q3. Please indicate the patient's diagnosis for the reque			
☐ Osteoporosis	☐ Other		
Q4. If the patient's diagnosis is OTHER, please speci	fv below:		
and the parameter and greeners to a recommendation of the	., 20.0		
OF lather affect a section of a section of the sect	of an fire atoms O		
Q5. Is the patient a post-menopausal female at high risk			
Yes	☐ No		
Q6. Is the patient at least 18 years of age or older?			
☐ Yes	□No		
Q7. Has the patient experienced a prior fragility fracture	?		
☐ Yes	□No		
_			
Q8. Does the patient have any of the following risk factor	ors for fracture (please sele	ect all that apply)?	
☐ Advanced age	☐ Rheumatoid a	rthritis	



Tymlos-4 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
☐ Parental history of fracture ☐ Low body mass index (BMI) ☐ Current smoker ☐ Chronic alcohol use	☐ Chronic steroid use ☐ Other secondary cause of osteoporosis ☐ None of the above
Q9. Has the patient failed an adequate trial of a bisphosp bisphosphonate trial?	honate (one year) or has a contraindication or intolerance to a
☐ Yes	□ No
Prescriber Signature	Date



Uptravi-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	Ctate Lie ID:
Group Number: Address:	NPI: Address:	State Lic ID:
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable	le):
*Please note that Envision will process the request as w		
· · · · · · · · · · · · · · · · · · ·	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions (OIO)		
Directions / SIG:		
Please attach any pertinent medical history or information	for this patient that may support	approval. Please answer the
	estions and sign.	
Q1. Is this request for initial or continuing therapy?		
	По и и	
☐ Initial therapy	☐ Continuing therapy	
Q2. If the request is for CONTINUING THERAPY, please	se provide the start date (MM/YY	′):
Q3. Please indicate the patient's diagnosis for the request	ed medication:	
☐ Pulmonary arterial hypertension (PAH) (WHO Group	Other	
	· .	
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Has the patient's diagnosis been confirmed by right he	eart catheterization?	
☐ Yes	□ No	
Q6. Has the patient tried and had an insufficient response	to at least one other PAH agent	(e.g. sildenafil)?
☐ Yes	□No	
Q7. Is the patient 18 years of age or older?		
☐ Yes	☐ No	



Uptravi-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:	
Prescriber Signature	Date	



Prescriber Signature

EOC ID:

Venclexta-6 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name	(if applicable):
*Please note that Envision will process the req	uest as written, including drug	g name, with no substitution.
	☐ Expedited/Urg	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or i	nformation for this patient that ma	ay support approval. Please answer the
Q1. Is this request for initial or continuing therap	py?	
☐ Initial therapy	☐ Continuing th	nerapy
Q2. For CONTINUING THERAPY, please inc	dicate the start date: (MM/YY):	
Q3. Please indicate the patient's diagnosis for the	ne requested medication: *	
☐ Acute myeloid leukemia (AML), newly diagn	osed	
☐ Chronic lymphocytic leukemia (CLL)/small ly☐ Other	ymphocytic lymphoma (SLL)	
Q4. For AML, please select all that apply to the	nis patient:	
☐ The patient is 75 years of age or olde	r	
☐ The patient has comorbidities that pre	clude use of intensive induction	chemotherapy
☐ Venclexta will be used in combination☐ None of the above	with azacitadine, decitabine, or	low-dose cytarabine
I	se specify below:	

Date



Venclexta-6 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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: Prescriber Name:



Verzenio-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if	applicable):
*Please note that Envision will process the request as v	vritten, including drug n	ame, with no substitution.
	☐ Expedited/Urger	nt
Drug Name and Strength:		
Directions / SIG:		
Discos office and marking of modical biotomy or information	- for this mation that many	aumant annual Blacca anaucartha
Please attach any pertinent medical history or information following qu	n for this patient that may lestions and sign.	support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing ther	apy
Q2. If the request is for CONTINUING THERAPY, plea	se provide the start date	(MM/YY):
Q3. Please indicate the patient's diagnosis for the reques	ted medication:	
☐ Breast cancer (advanced or metastatic)	☐ Other	
OA If the nationt's diagnosis is OTUED, places enseit	, bolow:	
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. For BREAST CANCER, please select all that apply to	this patient's disease:	
☐ The patient's disease is hormone receptor (HR)-po	sitive	
☐ The patient's disease is human epidermal growth fa	actor receptor 2 (HER2)-r	negative
☐ None of the above		
Q6. For BREAST CANCER, please select all that apply to	this patient's treatment:	
☐ Verzenio will be used as monotherapy	·	
☐ Verzenio will be used in combination with fulvestra	nt (Faslodex)	
_	` ,	th an aromatase inhibitor
☐ Verzenio will be used as initial endocrine-based treatment in combination with an aromatase inhibitor ☐ The national's disease has progressed following endocrine therapy.		
 ☐ The patient's disease has progressed following endocrine therapy ☐ The patient has already received at least one prior chemotherapy regimen of Ibrance or Kisqali 		
The patient has already received at least one phot		. Islando di Tadquii



Verzenio-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
☐ None of the above	
Q7. Is the medication being prescribed by (or in consultat	tion with) an oncologist?
☐ Yes	□ No
Q8. Is the patient 18 years of age or older?	
☐ Yes	□ No
Prescriber Signature	Date



Vitrakvi-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name: Prescr	iber Name:
Member/Subscriber Number: Fax:	Phone:
Date of Birth: Office	Contact:
Group Number: NPI:	State Lic ID:
Address: Addre	SS:
City, State ZIP: City, S	state ZIP:
Primary Phone: Specia	alty/facility name (if applicable):
*Please note that Envision will process the request as written,	including drug name, with no substitution.
	Expedited/Urgent
Drug Name and Strength:	
Directions / SIG:	
Please attach any pertinent medical history or information for this following questions	
Q1. Is this request for initial or continuing therapy?	
☐ Initial therapy	☐ Continuing therapy
Q2. For CONTINUING THERAPY, please provide the start da	te (MM/YY):
Q3. Please indicate the patient's diagnosis for the requested med	lication:
☐ Solid tumor	Other
Q4. If the patient's diagnosis is OTHER, please specify below:	
Q5. Is the patient's tumor neurotrophic receptor tyrosine kinase (NTRK) gene fusion positive without a known acquired
resistance mutation?	, , , , , , , , , , , , , , , , , , , ,
☐ Yes [□No
Q6. Please select all that apply to this patient:	
☐ The patient's disease is metastatic, or surgical resection is	likely to result in severe morbidity
☐ There is no satisfactory alternative treatment (or the patier	t has progressed following treatment)
☐ None of the above	
Q7. Is the requested medication being prescribed by (or in consu	Itation with) an oncologist?
	•
☐ Yes [□ No



Vitrakvi-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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: Prescriber Name:** Prescriber Signature Date



Vizimpro-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	FIIONE.
Group Number:	NPI:	State Lic ID:
Address:	Address:	0.0.0
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if	applicable):
*Please note that Envision will process the request as	written, including drug	name, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions / SIG:		
Directions / Sig.		
Please attach any pertinent medical history or information	on for this patient that may	support approval. Please answer the
following q	uestions and sign.	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	rany
Q2. For CONTINUING THERAPY, please provide the	e start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the reque	sted medication:	
☐ Non-small cell lung cancer (NSCLC), metastatic	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specif	fy below:	
, , , , , , , , , , , , , , , , , , , ,	,	
Q5. Is the patient's disease positive for epidermal growth	n factor receptor (EGFR)	exon 19 deletion or exon 21 (L858R)
substitution mutations as detected by an FDA approved		(
☐ Yes	□No	
Q6. Is the medication being prescribed by (or in consulta	ation with) an oncologist?	
☐ Yes	□ No	
□ 169		
Q7. Is the patient 18 years of age or older?		
☐ Yes	☐ No	



Vizimpro-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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.		e
Patient Name:	Prescriber Name:	
Prescriber Signature	Date	



Xalkori-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):
*Please note that Envision will process the request as	written, including drug	name, with no substitution.
	☐ Expedited/Urg	ent
Drug Name and Strength:		
Directions / OIC.		
Directions / SIG:		
Please attach any pertinent medical history or informati	ion for this patient that ma	y support approval. Please answer the
	4	
Q1. Is this request for initial or continuing therapy?		
☐ Initial Therapy	☐ Continuing Th	nerapy
Q2. If the request is for CONTINUING THERAPY, ple	ease provide the start dat	e (MM/YY):
Q3. Please indicate the diagnosis for which the request	ed medication is being pr	escribed:
☐ Non-small cell lung cancer, Metastatic, ALK-posit	tive	
☐ Non-small cell lung cancer, Metastatic, ROS1-po	sitive	
☐ Other		
Q4. If diagnosis is OTHER, please specify below:		
Q5. Is the prescribing physician an oncologist?		
☐ Yes	☐ No	
		



Xalkori-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Na	me:
	·	
Prescriber Signature		 Date



Xeljanz-13 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (i	f applicable):
*Please note that Envision will process the req	quest as written, including drug	name, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or i	information for this patient that may llowing questions and sign.	y support approval. Please answer the
Q1. Is this request for initial or continuing therap	oy?	
☐ Initial therapy	☐ Continuing the	erapy
Q2. For CONTINUING THERAPY, please pr	ovide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for t	he requested medication:	
☐ Psoriatic arthritis		
☐ Rheumatoid arthritis (moderately to severel	y active)	
☐ Ulcerative colitis (moderately to severely ac	tive)	
☐ Other		
Q4. For ULCERATIVE COLITIS, is the patier corticosteroids without a return of the symptom	·	s an inability to successfully taper
☐ Yes	□No	
Q5. If the patient's diagnosis is OTHER, plea	se specify below:	
Q6. Has the patient had failure, contraindication Methotrexate Enbrel (etanercept) Humira (adalimumab)	n, or intolerance to any of the follo	wing? (please select all that apply):



Xeljanz-13 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
☐ Oral aminosalicylate ☐ Oral corticosteroid ☐ Azathioprine ☐ 6-mercaptopurine ☐ None of the above	
Q7. If the patient has NOT tried any of the medications medications cannot be used (i.e. contraindication, history	listed in the previous question, is there a reason these bry of adverse event, etc)?
Q8. Does the patient have a documented needle-phobia injectable therapy or medical procedure? (refer to DSM-IV	·
☐Yes	□ No
Q9. Will the patient be receiving any of the following while	e taking Xeljanz?
 ☐ A biologic disease-modifying anti-rheumatic drug (I Cimzia (certolizumab), Simponi (golimumab)) ☐ A potent immunosuppressant (such as azathioprine 	DMARD) (such as Enbrel (etanercept), Humira (adalimumab),
☐ None of the above	e of Cyclosporme)
Prescriber Signature	 Date



Xgeva-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Deticat Name	Drag grib av Nama	
Patient Name: Prescriber Name:		
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:		
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if	applicable):
*Please note that Envision will process the request as v	vritten, including drug	name, with no substitution.
☐ Expedited/Urgent		
Drug Name and Strength:		
D: 11 / 100		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may lestions and sign.	support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	rany
Q2. For continuing therapy, please specify start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the reques	sted medication:	
☐ Bone metastases from solid tumors		
Giant cell tumor of the bone that is unresectable or where surgical resection is likely to result in severe morbidity		
Hypercalcemia of malignancy refractory to bisphosphonate therapy		
☐ Prevention of skeletal related events in patients with multiple myeloma		
☐ Other	, ,	
OA If the meticable discussion is OTLIFD, also as a secific	. In a large	
Q4. If the patient's diagnosis is OTHER, please specify	/ below:	
Q5. Does the patient have uncorrected hypocalcemia?		
☐ Yes	□No	



Xgeva-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
Prescriber Signature	Date



Xolair-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if application)	able):
*Please note that Envision will process the request as v	vritten, including drug name,	with no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
		of annual Disease annual to
Please attach any pertinent medical history or information following qu	n for this patient that may suppo lestions and sign.	ort approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
.,		
Q2. If the request is for CONTINUING THERAPY, plea	se provide the start date (MM/	/Y):
Q3. What is the patient's diagnosis for the requested med	lication? *	
☐ Chronic idiopathic urticaria		
☐ Moderate to severe persistent allergic asthma		
☐ Other		
Q4. FOR URTICARIA, does the patient remain sympton	matic despite H1 antihistamine	treatment?
	<u></u>	a caunone.
Yes	□ No	
Q5. FOR CONTINUING THERAPY: Has a demonstrat	ed improvement in asthma con	trol been noted?
☐ Yes	□No	
OO FOR ACTUMA also a select all that a relate this	- North	
Q6. FOR ASTHMA, please select all that apply to this		
Patient has evidence of specific allergic sensitiv		, , ,
blood test (i.e. radioallergosorbent test) for a specific		renniai aeroaliergen
Pretreatment serum IgE levels are greater than		sectionald (ICC) plant land and
Patient's symptoms are not adequately controlle	_	
beta2-agonist (LABA) for at least 3 months OR members	Dei Has documented intolerance	E to 103 of LADA OR Hember



Xolair-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
has a contraindication to ICS or LABA None of the above	
Q7. If the patient's diagnosis is OTHER, please specify	below:
Q8. Please indicate the patient's age below:	
☐ Under 6 years	6 years or older
Q9. Please indicate the prescriber's specialty below: Allergist Immunologist Pulmonologist Dermatologist Other Q10. If the prescriber's specialty is OTHER, please specialty	ecify:
Prescriber Signature	Date



Xospata-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name	e (if applicable):
Please note that Envision will process the re	equest as written, including dru	ig name, with no substitution.
	☐ Expedited/U	rgent
Orug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or		nay support approval. Please answer the
f	following questions and sign.	
Q1. Is this request for initial or continuing there	apy?	
Q1. Is this request for initial or continuing there	apy?	herapy
	☐ Continuing t	herapy
☐ Initial therapy Q2. For CONTINUING THERAPY, please p	☐ Continuing to	herapy
☐ Initial therapy	☐ Continuing to	herapy
☐ Initial therapy Q2. For CONTINUING THERAPY, please p	Continuing to crovide the start date (MM/YY):	herapy
☐ Initial therapy Q2. For CONTINUING THERAPY, please p Q3. Please indicate the patient's diagnosis for	Continuing to provide the start date (MM/YY): the requested medication: ractory	herapy
☐ Initial therapy Q2. For CONTINUING THERAPY, please p Q3. Please indicate the patient's diagnosis for ☐ Acute myeloid leukemia, relapsed or refr	Continuing to provide the start date (MM/YY): the requested medication: ractory	herapy
☐ Initial therapy Q2. For CONTINUING THERAPY, please p Q3. Please indicate the patient's diagnosis for ☐ Acute myeloid leukemia, relapsed or refr Q4. If the patient's diagnosis is OTHER, please	Continuing to crovide the start date (MM/YY): the requested medication: ractory	herapy
☐ Initial therapy Q2. For CONTINUING THERAPY, please p Q3. Please indicate the patient's diagnosis for ☐ Acute myeloid leukemia, relapsed or refr Q4. If the patient's diagnosis is OTHER, please.	Continuing to crovide the start date (MM/YY): the requested medication: ractory Other ase specify below:	herapy
☐ Initial therapy Q2. For CONTINUING THERAPY, please p Q3. Please indicate the patient's diagnosis for ☐ Acute myeloid leukemia, relapsed or refr Q4. If the patient's diagnosis is OTHER, please	Continuing to crovide the start date (MM/YY): the requested medication: ractory	herapy
☐ Initial therapy Q2. For CONTINUING THERAPY, please p Q3. Please indicate the patient's diagnosis for ☐ Acute myeloid leukemia, relapsed or refr Q4. If the patient's diagnosis is OTHER, please.	Continuing to crovide the start date (MM/YY): the requested medication: ractory Other ase specify below:	herapy
☐ Initial therapy Q2. For CONTINUING THERAPY, please p Q3. Please indicate the patient's diagnosis for ☐ Acute myeloid leukemia, relapsed or refr Q4. If the patient's diagnosis is OTHER, please. Q5. Are FLT3 mutations present as detected be ☐ Yes	Continuing to crovide the start date (MM/YY): the requested medication: ractory Other ase specify below:	herapy
☐ Initial therapy Q2. For CONTINUING THERAPY, please p Q3. Please indicate the patient's diagnosis for ☐ Acute myeloid leukemia, relapsed or refr Q4. If the patient's diagnosis is OTHER, please Q5. Are FLT3 mutations present as detected b ☐ Yes Q6. Is the patient 18 years of age or older?	Continuing to provide the start date (MM/YY): the requested medication: ractory	



Xospata-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
Prescriber Signature	Date



Xpovio-12 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):
*Please note that Envision will process the request a	as written, including drug	name, with no substitution.
	☐ Expedited/Urg	ent
Drug Name and Strength:		
Directions / SIG:		
Discount of the control of the contr		
Please attach any pertinent medical history or information following	ation for this patient that ma g questions and sign.	y support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
│	☐ Continuing the	erapy
.,	-	.,
Q2. For CONTINUING THERAPY, please provide t	the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the req	uested medication:	
☐ Multiple myeloma (relapsed or refractory)	☐ Other	
0.15		
Q4. If the patient's diagnosis is OTHER, please spe	ecity below:	
Q5. Will the requested medication be used in combina	ation with dexamethasone?	
Yes	☐ No	
	•	
Q6. Has the patient received at least 4 prior therapies		
Yes	☐ No	
Q7. Is the patient's disease refractory to any of the fol	lowing (please select all tha	at apply)?
At least two proteasome inhibitors	.og (prodeo coroci dii iii	
At least two immunomodulatory agents		
An anti-CD38 monoclonal antibody		
None of the above		



Xpovio-12 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
Q8. Is the patient 18 years of age or older?	
☐Yes	□ No
Q9. Is the requested medication prescribed by, or in cons	ultation with, an oncologist or hematologist?
☐Yes	□No
Prescriber Signature	Date



Xtandi-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Nam	ne:
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility	name (if applicable):
*Please note that Envision will pro	ocess the request as written, includin	ng drug name, with no substitution.
	☐ Exped	lited/Urgent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medi	cal history or information for this patient following questions and sign	that may support approval. Please answer the n.
Q1. Is this request for initial or cor	_	uing therapy
miliar therapy		turing therapy
Q2. If the request is for CONTII	NUING THERAPY, please provide the s	start date (MM/YY):
Q3. Please indicate the patient's of	diagnosis for the requested medication b	pelow:
☐ Prostate Cancer (metastatic, o	castration-resistant)	
☐ Prostate Cancer (non-metasta	atic, castration-resistant)	
Q4. FOR Metastatic prostate ca	ancer: Has the patient tried and failed Zy	ytiga?
☐ Yes	□No	
Q5. If the patient has not trich history of adverse event, etc.		tion cannot be used (i.e. contraindication,
Q6. If diagnosis is OTHER, ple	ase specify below:	
Q7. Please indicate the Prescribe	r's specialty:	
☐ Oncologist	☐ Urologist	☐ None of the above



Xtandi-2 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:	
Q8. Is the patient 18 years of age or older?		
☐ Yes	□ No	
Prescriber Signature		Date



Xuriden-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (i	f applicable):
*Please note that Envision will process the	request as written, including drug	name, with no substitution.
	☐ Expedited/Urg	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history	or information for this patient that ma following questions and sign.	y support approval. Please answer the
O1 to this request for initial or continuing the	orany?	
Q1. Is this request for initial or continuing the	•	
☐ Initial therapy	☐ Continuing the	erapy
Q2. For CONTINUING THERAPY, please	provide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for	or the requested medication:	
☐ Hereditary orotic aciduria	☐ Other	
Q4. If the patient's diagnosis is OTHER, p	lease specify below:	
	, •	
Prescriber Signature		Date



Xuriden-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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	Prescriber Name	
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Xyrem-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if	applicable):
*Please note that Envision will process	the request as written, including drug n	ame, with no substitution.
	☐ Expedited/Urger	nt
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical hist	ory or information for this patient that may following questions and sign.	support approval. Please answer the
Q1. Is this request for initial or continuing	g therapy?	
☐ Initial therapy	☐ Continuing then	anv
Q2. For continuing therapy, please sp	ecify start date (MM/YY):	
Q3. Please indicate the patient's diagnos	sis for the requested medication: *	
☐ Excessive daytime sleepiness	·	
	ed by weak or paralyzed muscles) in patie	ents with narcolepsy
☐ Other	,, p,,	
OA If the particular discussion is OTHE	D. mlaassa amasif i balanin	
Q4. If the patient's diagnosis is OTHE	R, please specify below:	
Q5. Is that patient taking or receiving any benzodiazepines, or ethanol?	y of the following: anxiolytics, sedatives, hy	ypnotics, barbiturates,
☐ Yes	□No	
OS FOR CONTINUING THEBADY has the	he nationt experienced a decrease is doubt	ima elaaninase and/or astanlavi/2
	he patient experienced a decrease in dayt	ime sieepiness and/or catapiexy?
Yes	□ No	



Xyrem-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

	Certain requests for coverage require review with the prescribing physician. Please mber listed above. Please note any information left blank or illegible may delay the
Patient Name:	Prescriber Name:
Prescriber Signature	Date



Yonsa-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if	fapplicable):
*Please note that Envision will process the request as	written, including drug	name, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
D' (1910)		
Directions / SIG:		
Please attach any pertinent medical history or information	on for this patient that may	y support approval. Please answer the
	uestions and sign.	
O1 to this request for initial or continuing thereby?		
Q1. Is this request for initial or continuing therapy?	_	
☐ Initial therapy	☐ Continuing the	rapy
Q2. For CONTINUING THERAPY, please provide the	start date (MM/YY):	
	,	
Q3. Please indicate the patient's diagnosis for the reque	sted medication below:	
☐ Prostate Cancer (metastatic, castration-resistant)	☐ Other	
Troctate carried (metastatic, castration resistant)		
Q4. If the patient's diagnosis is OTHER, please specif	fy below:	
Q5. Will the requested medication be used in combination	on with methylprednisolon	e?
☐ Yes	□No	
Q6. Has the patient tried and failed (or has an intolerance	e or contraindication to) 2	Zytiga (abiraterone)?
☐ Yes	☐ No	
Q7. Is the patient 18 years of age or older?		
☐ Yes	☐ No	
Q8. Is the medication being prescribed by (or in consulta	ation with) an oncologist o	r urologist?



Yonsa-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Name:
☐ Yes	□No
Prescriber Signatur	e Date



Zejula-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):
*Please note that Envision will process the request	t as written, including drug	name, with no substitution.
	☐ Expedited/Urg	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or inform followi	nation for this patient that ma ng questions and sign.	y support approval. Please answer the
	· · · · · · · · · · · · · · · · · · ·	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	erany
Q2. If the request is for CONTINUING THERAPY	, please provide the start dat	e (MM/YY):
Q3. Please indicate the patient's diagnosis for the re	equested medication:	
Ovarian cancer (recurrent, epithelial)		
Fallopian tube cancer (recurrent)		
☐ Primary peritoneal cancer (recurrent)		
☐ Other		
Q4. If the patient's diagnosis is OTHER, please s	pacify halow:	
Q4. If the patient's diagnosis is Official, piease s	pecity below.	
Q5. Has the patient had a complete or partial respor	nse to platinum-based chemo	therapy?
☐ Yes	☐ No	
Q6. Is Zejula being prescribed by (or in consultation	with) an oncologist or gynec	ologist?
☐ Yes	□ No	
□ 169	INO	
Q7. Is the patient 18 years of age or older?		
☐ Yes	☐ No	



Fax back to: 877-503-7231

EOC ID:

Phone: 800-361-4542

Zejula-1 Medicare

Rx 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:	Prescriber Name:
Prescriber Signature	Date



Zykadia-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility nam	ne (if applicable):
Please note that Envision will process th	e request as written, including dr	rug name, with no substitution.
	☐ Expedited/U	Jrgent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical histor	ry or information for this patient that following questions and sign.	may support approval. Please answer the
Q1. Is this request for initial or continuing t	herapy?	
☐ Initial therapy	☐ Continuing	therapy
OO If the measure tie few CONITIAL HAIG T		data (NANANAN).
Q2. If the request is for CONTINUING T	HERAPY, please provide the start (date (MM/YY):
Q3. What is the patient's diagnosis for the	requested medication: *	
☐ Anaplastic lymphoma kinase (ALK)-p non-small cell lung cancer (NSCLC)	oositive metastatic	
Q4. If the patient's diagnosis is OTHER,	, please specify below:	
Prescriber Signature		Date



Zykadia-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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: Prescriber Name:



Zytiga-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name	(if applicable):
*Please note that Envision will process the request as v	vritten, including drug	name, with no substitution.
	☐ Expedited/Urg	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information		ay support approval. Please answer the
ioliowing qu	estions and sign.	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing th	erany
		етару
Q2. If the request is for CONTINUING THERAPY, plea	se specify the start dat	e (MM/YY):
Q3. Please indicate the patient's diagnosis for the reques	ted medication:	
☐ Metastatic prostate cancer (castration-resistant or		
high-risk castration-sensitive)	☐ Other	
O4 If the nationt's diagnosis is OTUED places enseit	, bolove	
Q4. If the patient's diagnosis is OTHER, please specify	below.	
Q5. Will Zytiga be used combination with prednisone?		
☐ Yes	☐ No	
		



Zytiga-1 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231

Rx 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:	Prescriber Nan	ne:	
	·		
Prescriber Signature		Date	-