

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.	y 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

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:



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.
y, State ZIP: mary Phone: City, State ZIP: 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?	,



Adempas-2 Medicare

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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):	
rimary Phone: Specialty/facility name (if applicable):			
*Please note that Envision will process the reque	<u>_</u>	•	
□ Expedited/Urgent			
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 THERAPY, please provide the start date (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 considered the benefits of use versus the potential risks of serious cardiovascular events?			
☐Yes		□No	
Q9. Will the patient be using an MAOI concurrently with the 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:		
imary 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

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



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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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. 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



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	urologist?
☐ Yes	☐ No	
Q8. Does the patient have any of the following	ng (please select all that apply)?	



Prescriber Signature

EOC ID:

Ampyra-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:** ☐ History of seizure Moderate or severe renal impairment (creatinine clearance less than or equal to 50 mL/minute) ☐ None of the above

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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 office have nowinger modical 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 contraindication	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



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 (please select all that apply)?	l intolerance or contraindication to) any of the following
☐ 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/Urg	ent
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

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



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



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	pplicable):
*Please note that Envision will process the request as v	vritten, including drug na	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 s	upport approval. Please answer the
	estions and sign.	apport approvant riouse another the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therap	ру
Q2. If the request is for CONTINUING THERAPY, plea	se provide the start date (N	/IM/YY):
,		,
Q3. Please indicate the patient's diagnosis for the reques	ted medication:	
Philadelphia chromosome-positive (Ph+) chronic mye		(obrania appelarated or blact phase)
Philadelphia chromosome-positive (Ph+) chronic mye	• ,	
Other	logerious leukernia (OML)	(newly diagnosed chronic phase)
Q4. For Ph+ CML IN THE CHRONIC, ACCELERATED		
or inadequate response to prior therapy with one of the apply)?	e following tyrosine kinase i	nnibitors (TKI) (please select all that
Gleevec (imatinib)		
Sprycel (dasatinib)		
☐ Tasigna (nilotinib)		
☐ None of the above		
Q5. If the patient has NOT tried any of the medicati		
medications cannot be used (i.e. contraindication, h	nistory of adverse event, dis	sease is resistant or intolerant,
etc)?		



Bosulif-4 Medicare

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

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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



Cabometyx-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 v	vritten, including drug n	name, with no substitution.
	☐ Expedited/Urger	nt
Drug Name and Strength:		
Directions / CIC.		
Directions / SIG:		
Please attach any pertinent medical history or informatio	n for this nationt that may	support approval. Please answer the
following qu	estions and sign.	support approval. I lease allower the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing ther	ару
Q2. If the request is for CONTINUING THERAPY, plea	se provide the start date	(MM/YY)·
q2. If the request is its destribute its arrange it, place	ico provido trio otari dato	((•, 1).
	tod modication:	
O2 Places indicate the national diagnosis for the regues	ieo medicanon.	
Q3. Please indicate the patient's diagnosis for the reques		
Q3. Please indicate the patient's diagnosis for the reques Renal cell carcinoma (advanced)	☐ Other	
	☐ Other	
Renal cell carcinoma (advanced)	☐ Other	
☐ Renal cell carcinoma (advanced) Q4. If the patient's diagnosis is OTHER, please specify	☐ Other	
Renal cell carcinoma (advanced)	☐ Other	



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	s written, including drug	name, with no substitution.	
	☐ Expedited/Urg	gent	
Drug Name and Strength:			
Directions / SIG:			
Please attach any pertinent medical history or information	tion for this patient that ma questions and sign.	ay support approval. Please answer the	
	1		
Q1. Is this request for initial or continuing therapy?			
☐ Initial therapy	☐ Continuing therapy		
Continuing therapy			
Q2. If the request is for CONTINUING THERAPY, pl	lease provide the start dat	te (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requ	ested medication:		
☐ Mantle cell lymphoma (MCL) ☐ Other			
Q4. If the patient's diagnosis is OTHER, please spec	cify below:		
Q5. Has the patient received at least one (1) prior there	apy for MCL?		
☐ Yes	☐ No		
Q6. Is Calquence being prescribed by (or in consultation	on with) an oncologist?		
☐ Yes	□No		
Q7. Is the patient 18 years of age or older?			
☐ Yes	☐ No		



Fax back to: 877-503-7231

EOC ID:

Phone: 800-361-4542

Calquence-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	



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 bours not deteriors to deteriors the many 100// from bookline)	ch as symptomatic im	provement 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:	
der in the patients shagnoons to a record,		
OS Has the diagnosis been confirmed by appropriate dia	anastia or ganatia tas	ting?
Q6. Has the diagnosis been confirmed by appropriate dia		ung:
☐ Yes ☐ No		
Q7. Does the patient have evidence of P. aeruginosa in the	ne 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	



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:			
mary 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:				
Diagon office and marking of modical biotomy or information	tion for this mations that was	ny avenant amazaval. Places amazavatka		
Please attach any pertinent medical history or informat following	tion for this patient that maging questions and sign.	ay support approval. Please answer the		
Q1. Is this request for initial or continuing therapy?				
☐ Initial therapy	☐ Continuing th	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 requ	ested medication:			
☐ Chronic heart failure (stable, symptomatic) ☐ Other				
Q4. If the patient's diagnosis is OTHER, please spec	cify below:			
Q5. Is the patient's left ventricular ejection fraction (LVI	EF) 35% or less?			
☐ Yes	□No			
Q6. Is the patient in sinus rhythm with resting heart rate	e of 70 beats per minute of	or more?		
☐ Yes	☐ No			
Q7. Is the patient on maximally tolerated doses of beta	hlockers OP has a contro	aindication to beta blocker use?		
		annulcation to beta blocker use?		
Yes	☐ No			
Q8. Is the patient 18 years of age or older?				
, , ,				



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:
☐ Yes	□ No
Q9. Does the patient have any of the following (please se	elect all that apply)?
☐ Decompensated acute heart failure	
☐ Hypotension (i.e. blood pressure less than 90/50 m	nmHg)
☐ Sick sinus syndrome, sinoatrial block, or 3rd degre	e AV block (unless a functioning demand pacemaker is
present)	
☐ Bradycardia (i.e. resting heart rate is less than 60 t	peats 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	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	☐ Continuing 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/Urg	ent
Drug Name and Strength:		
Directions / SIG:		
niections / 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



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 (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:		
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 the	erany
Q2. For CONTINUING THERAPY, please	indicate the start date (MM/YY).	
Q3. Please indicate the patient's diagnosis for	or the requested medication:	
☐ Actinic keratosis	☐ Other	
Q4. If the patient's diagnosis is OTHER, p	lease specify below:	
		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 ı	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 the	тару
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	otherapy or radiation regimen?
☐Yes	□No
Q8. FOR N/V: Is oral drug being used as a full therape a cancer chemotherapeutic regimen administered with	utic replacement for an intravenous anti-emetic drug as part of in 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	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?	atient 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

Potent Manage		
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		support approval. Please answer the
tollowing q	uestions and sign.	
O4 to this request for initial or continuing thereas?		
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)	
Q2.1 of CONTINUING THEIR 1, picase provide the	start date (will, 1 1).	
Q3. Please indicate the patient's diagnosis for the reque	sted 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 specif	fv below:	
and passent alagnosis is a mining places open.	., 20.0	
Q5. Do any of the following apply to this patient (please	select all that apply)?	
The patient has an active serious infection (including	,	
☐ The patient will be using Enbrel with another biolo	gic disease-modifying ant	ti-rheumatic drug (DMARD)
☐ The patient will be using Enbrel with potent immunosuppressant (such as azathioprine 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 dru	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 (such as methotrexate, cyclosporine, acitretin, sulfasalazine) for at least 3 consecutive months		
☐ 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 (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:		
Directions / GIG.		
Please attach any pertinent medical history or information following of	on for this patient that may	y 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 reque	sted medication:	
☐ Sickle cell disease (acute)	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify below:		
Q5. Has the patient tried and failed (or has an intolerance	e or contraindication to) h	nydroxyurea?
☐ 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 within 36 hours of an ACE-inhibitor		
☐ Entresto will be used concomitantly with aliskiren (Tekturna) in a diabetic patient ☐ None of the above		
☐ 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	 Dat	te



Erleada-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:	Thoric.
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 following qu	n for this patient that may suppo estions 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:	
☐ Prostate cancer (non-metastatic) ☐ Other		
Q4. If the patient's diagnosis is OTHER, please specify below:		
Q5. Is the patient's disease castration-resistant?		
☐ Yes	□ No	
Q6. Is the patient 18 years of age or older?		
Yes	□ No	
Q7. Is the requested medication being prescribed by (or i	n consultation with) an oncolog	ist or urologist?
☐ Yes	□No	
Q8. Is the patient pregnant?		
☐ Yes		



Erleada-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:** □ No □ N/A - The patient is not a female or not of child-bearing potential 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 appli	cable):
*Please note that Envision will process the request as v	vritten, including drug name	e, with no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informatio	n for this natient that may sun	nort approval Please answer the
	estions and sign.	sort approvant rouge unester the
Q1. Is this request for initial therapy or continuing therapy	? *	
☐ Initial therapy	☐ Continuing therapy	
Q2. For CONTINUING THERAPY, please specify the start date (MM/YY):		
q2.161 GOTTING TO THE TOTAL 1, placed opedity and	start dato (WWW 1 1).	
OO Discourie that the methods discourse is for the mount	And an altertance *	
Q3. Please indicate the patient's diagnosis for the reques		
Anemia associated with chronic kidney disease (CKD	,	
Anemia associated with myelosuppressive chemothe	• •	
Anemia associated with zidovudine therapy in a patie		
Reduction of blood transfusions in a patient undergoi	ng elective, non-cardiac, non-	vascular surgery
Other		
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Is the patient's pre-treatment hemoglobin level less the	nan 10 g/dL?	
☐ Yes	☐ No	
	□ 140	
Q6. Will there be a dose reduction or interruption if the he	-	<u> </u>
CKD not on dialysis, or cancer); 11 g/dL (CKD on dialysis); or 12 g/dL (pediatric CKD)?		?
☐ Yes	☐ No	



ESA-1 Medicare

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

Patient Name:	Prescriber Name:	
Prescriber Signatu	e Date	



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 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 therapy	
Q2. For CONTINUING THERAPY, please specify the 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 app	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 in consultation with) an oncologist/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

	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 following quantum followi	on for this patient that may suestions and sign.	support approval. Please answer the
3.3.3.1		
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing thera	any
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	□ .	
patient)	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specif	y holow:	
Q4. If the patient's diagnosis is OTTIEN, 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) 3A4	inhibitore (euch as aprenitant
clarithromycin, diltiazem, erythromycin, fosamprenavir, fl	· · · · ·	
ritonavir, verapamil) will they be monitored or have dosin		
☐ Yes	-	•
□ No		
☐ N/A - Patient is not taking any strong CYP450 3A4 in	hibitors	
Q7. The plan has the following quantity limits in place: 12	20 lozendes per 30 days. V	Vill the nationt require a quantity
Q7. The plan has the following quantity limits in place. 12		viii the patient 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 prolong survival or cure the disease		
☐ For the treatment of febrile neutropenia in patients who have received prophylaxis 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 ☐ None of the above	d complications
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



Gilotrif-2 Medicare

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

Patient Name:	Prescriber Name:	
		Dhara
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 as v		
<u> </u>	☐ Expedited/Urger	nt
Drug Name and Strength:		
Directions / SIG:		
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 ther	ару
Q2. For CONTINUING THERAPY, please provide the	start date (MM/YY):	
O2 Places indicate the national diagnosis for the reques	tad madigation:	
Q3. Please indicate the patient's diagnosis for the reques	ileu medication.	
Non–small cell lung cancer (NSCLC), metastaticNon-small cell lung cancer (NSCLC), metastatic so	wamaya (proviously troot	od)
Other	qualificus (previously treat	eu)
Q4. Has the patient's disease progressed following pla	tinum-based chemothera	 py?
☐Yes	☐ No	
Q5. If the patient's diagnosis is OTHER, please specify	below:	
Q6. Do the patient's tumors have non-resistant epidermal FDA-approved test?	growth factor receptor (E	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 immedi	iate 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 request a	ns written, including drug	name, with no substitution.
	☐ Expedited/Urg	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informa	ation for this patient that ma	y support approval. Please answer the
Tonowing	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	he start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requ	uested medication:	
☐ Chronic Hepatitis C	☐ Other	
Q4. If the patient's diagnosis is OTHER, please spe	cify below:	
Q5. Is the patient 18 years of age or older?		
☐ Yes	□No	
Q6. Please indicate the prescriber's specialty below:		
☐ Gastroenterologist		
☐ Hepatologist		
☐ Infectious Disease Specialist		
☐ Other		
Q7. If the prescriber's specialty is OTHER, please s	pecify:	
	· ·	
I .		



Hepatitis C-1 Medicare

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

Patient Name:	Prescriber Name:
Q8. Please provide the patient's genotype confirmed by F documentation):	HCV RNA level within the last 6 months (must submit
Q9. Please provide the patient's subtype (must submit do	ocumentation):
Q10. Please provide the patient's HCV RNA (viral load) le	evel (must submit documentation):
Q11. Is the patient post-transplant?	
☐Yes	□ No
Q12. What is the patient's cirrhosis status?	
Q13. What is the patient's prior treatment history?	
Q14. What is the patient's planned duration of treatment?	•
Q15. Has the prescriber documented the following within AST/ALT, 3) Total Bilirubin, 4) Serum Albumin, 5) PT/INR	
☐Yes	□ No
Q16. For Vosevi: Has the patient previously tried and faile Yes No N/A - The request is for Mavyret	ed (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

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 v	vritten, including drug name, wi	th 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 therapy	
Q2. For CONTINUING THERAPY, please provide the	start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the reques	ted medication:	
☐ Non-24-hour-sleep-wake disorder (Non-24)	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify below:		
Q5. Does the patient have documented blindness?		
Yes	□No	
Q6. Is the patient 18 years of age or older?		
☐ Yes	□ No	



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:
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 w	vritten, including drug n	ame, with no substitution.
	☐ Expedited/Urgen	t
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that may s estions and sign.	support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial	☐ Continuing	
Q2. For continuing therapy, please specify start date (N	/IM/YY):	
Q3. Is the patient greater than or equal to 65 years of age	9?	
☐ Yes	☐ No	
Q4. Please indicate the diagnosis for which the requested	medication is being pres	cribed:
☐ Attention deficit hyperactivity disorder (ADHD) ☐ Hypertension	.	
☐ Other		
Q5. If the diagnosis is OTHER, please specify.		



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 anomer 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?	
_	,	
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		



Fax back to: 877-503-7231

EOC ID:

Phone: 800-361-4542

HRM Analgesics-3 Medicare

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please



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		
ty, State ZIP:	City, State ZIP:	
imary Phone:	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.	the 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?		
Initial	☐ Continuing	
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:		
OF Plagas provide the national diagnosis hele		
Q5. Please provide the patient's diagnosis below:		
Obsessive-Compulsive Disorder		
☐ Depression		
Anxiety		



Prescriber Signature

EOC ID:

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. **Patient Name: Prescriber Name:** ☐ Enuresis ☐ Other Q6. If the diagnosis is OTHER, please specify. Q7. Is the patient greater than or equal to 65 years of age? ☐ Yes ☐ No

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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:	
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:		
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 артогант толог аноног ано
		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:		
nary Phone: Specialty/facility name (if applicable):		pplicable):	
*Please note that Envision will process th	e request as written, including drug na	nme, with no substitution.	
☐ Expedited/Urgent			
Drug Name and Strength:			
Discribed (212)			
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 In this request for initial or continuing t	thoranu2		
Q1. Is this request for initial or continuing therapy?			
☐ Initial therapy	Continuing thera	ру	
Q2. For continuing therapy, please spec	cify 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	specify helow:		
Q4. If the diagnosis is Official, please of	specify below.		
Q5. Is the patient greater than or equal to	65 years of age?		
Yes	□ No		
□ 163			



HRM Antihistamines-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 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



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 may	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:	
Леmber/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
Orug Name and Strength:		
Directions / SIG:		
onections / ord.		
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 is OTLIFD places on	a aif. It alann	
Q4. If the diagnosis is OTHER, please sp	decily below.	
	7	
Q5. Is the patient greater than or equal to 6	<u></u>	
Yes	☐ No	
Q6. FOR PRESCRIBER INFORMATION O	NLY: Formulary non-HRM alternatives	s are as follows: 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	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		ny support approval. Please answer the
following	ng questions and sign.	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing th	erapy
Q2. For CONTINUING THERAPY, please indicate	e Start Date (MM/YY):	
Q3. Please indicate the patient's diagnosis:		
☐ Insomnia	☐ Other	
Q4. If the patient's diagnosis is OTHER, please sp	pecify below:	
Q5. Is the patient greater than or equal to 65 years o	f 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:		
imary 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 ap	proval. 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):			
q2.1 or containing arotapy, produce opening and ottain date	(
O2 Plages indicate the nationt's diagnosis for the requests	d modination:		
Q3. Please indicate the patient's diagnosis for the requeste	_		
☐ Ankylosing Spondylitis	☐ Polyarticular juvenile idiopat	inic arthritis (pJIA)	
Crohn's Disease (moderate to severe)	(moderate to severe) ☐ Psoriatic arthritis		
Hidradenitis suppurativa (moderate to severe)		rata ta savara)	
Non-infectious Uveitis (including intermediate, posterio	·	· ·	
and panuveitis)	Ulcerative colitis (moderate	to severe)	
☐ Plaque psoriasis (chronic)	☐ Other		
Q4. For PLAQUE PSORIASIS, does the patient's disease		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 contraindication that apply 2	on or intolerance to) any of the follo	owing (please select all	
that apply)?			



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	
i aliciil Nailic.	i i escibei italiie.	

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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:	one: 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 / CIC.			
Directions / SIG:			
Please attach any pertinent medical history or inform	ation for this patient that ma	y support approval. Please answer the	
IOIIOWIII	g questions and sign.		
Q1. Is this request for initial or continuing therapy?			
☐ Initial therapy	☐ Continuing th	erapy	
Q2. For CONTINUING THERAPY, please indicate	the start date (MM/YY):		
Q3. Please indicate the patient's diagnosis for the rec	quested medication:		
☐ Breast cancer, advanced or metastatic (initial end	locrine-based therapy)		
☐ Breast cancer, advanced or metastatic (second-li	ne endocrine-based therapy	у)	
Q4. Is the patient a post-menopausal female?			
☐Yes	□No		
Q5. Did the patient experience disease progression	n following previous endocr	ine based therapy?	
☐ Yes	☐ No		
Q6. If the patient's diagnosis is OTHER, please spe	ecify below:.		
Q7. Is the patient's disease hormone receptor (HR)-p negative?	ositive, human epidermal g	rowth factor receptor 2 (HER2)-	
☐ Yes	☐ No		



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

Patient Name:	Prescriber Name:
Q8. Will any of the following medications be used in coml Aromatase inhibitor such as letrozole (Femara) Fulvestrant (Faslodex) None of the above	bination with Ibrance (please select all that apply)?
Q9. Is the patient 18 years of age or older?	
☐Yes	□ No
Q10. Is the medication prescribed by or in consultation w	ith 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 CONTINUING THERAPY, please provide the start 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 0	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:	eflili-).
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?		
☐ 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	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	



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, please 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 re	•	
Marginal zone lymphoma, relapsed/refractory (in patients who require systemic therapy)		
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:	
		5
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:	
Oity, State 21F. Primary Phone:	Specialty/facility name (if a	onlicable).
•		
*Please note that Envision will process	the request as written, including drug na	me, with no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Directions / Gio.		
Please attach any pertinent medical hist	tory or information for this patient that may s	unnort annroval. Please answer the
r lease attach any pertinent medicar mst	following questions and sign.	upport approval. I lease answer the
Q1. Is the request for initial or continuing	therapy?	
☐ Initial therapy	☐ Continuing thera	ру
Q2. For CONTINUING THERAPY, ple	ease specify the start date (MM/YY):	
Q3. Please indicate the patient's diagnos	sis for the requested medication: *	
☐ Severe primary insulin-like growth fa	ctor-1 deficiency (IGF-1 deficiency; primary	IGFD)
☐ Growth hormone (GH) gene deletion	in a patient that has developed neutralizing	g antibodies to growth hormone
☐ Genetic mutation of GH receptor (i.e	. Laron Syndrome)	
☐ Other		
Q4. If the diagnosis is OTHER, please	specify below:	
a in the diagnosis is a mark, product	opesity below.	
	h retardation with height standard deviation	score (SDS) more than 3 SDS
below the mean for chronological age an	<u></u>	
Yes	☐ No	
Q6. Is the patient's IGF-1 level greater th	nan or equal to 3 standard deviations below	normal based on lab reference
range for age and sex?	4	
☐ 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:	P	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 epiph	nyses?		
☐ Yes		☐ No	
Q9. Does the patient have allergies	to mecasermin or any co	omponent of the Increl	lex formulation?
☐ Yes		☐ No	
Q10. Will the medication be used for	or growth promotion in pa	tients with closed epip	physes?
☐ Yes		☐ No	
Q11. Will Increlex be administered	intravenously?		
☐ Yes		☐ No	
Q12. Does the patient have active of	or suspected neoplasia?		
☐ Yes		☐ No	
Q13. Please indicate the prescriber	's specialty below:		
☐ Pediatrics	☐ Endocrinologi	st	☐ Other
Q14. If the prescriber's specialty is other, please describe below:			
Prescriber Signatu	ıre		 Date



Intrarosa-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 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 p	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	
Q6. Is the patient 18 years of age or older?		
☐ Yes	□No	
□ 163		
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' (1 1 - 1 - 1 - 1 - 1 - 1 -		
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.		
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 in Northansiasional dependent trial assernia syndromes Chronic iron overload due to blood transfusions		
☐ 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>	<u> </u>



Prescriber Signature

EOC ID:

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

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Date



Itraconazole-1 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	applicable):	
*Please note that Envision will process t	he 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	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	☐ Initial therapy ☐ Continuing therapy		
Q2. For continuing therapy, please spe	ecify start date (MM/YY):		
Q3. Please indicate the diagnosis for which	ch Itraconzole is being requested: *		
☐ Blastomycosis (pulmonary or extra	pulmonary)		
☐ Histoplasmosis (including chronic o	cavitary pulmonary disease or disseminate ulmonary)	ed, non-meningeal histoplasmosis)	
	or without finger nail involvement, due to	dermatophytes (tinea unguium)	
	lue to dermatophytes (tinea unguium)		
Q4. If the diagnosis is OTHER, please	specify below:		
Q5. For ONYCHOMYCHOSIS, has the di preparation, fungal culture, or nail biopsy)	_	ıl diagnostic test (e.g., KOH	
☐Yes	□No		
Q6. Does the patient have ventricular dys	function (e.g., congestive heart failure (C	HF) or history of CHF)?	
☐ Yes ☐ No			
	□•		



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:	
	Q7. Is the patient is currently taking any drugs metabolized by CYP3A4 (e.g., cisapride, dofetilide, pimozide, quinidine)?		
	☐ Yes	□No	
_			
	Prescriber Signature	Date	



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	☐ Continuing th	perany
<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 an anageres is a realized to poonly	 	



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 select all that apply)? Moderate to severe liver impairment Active liver disease including unexplained persistent abnormal liver function tests Pregnant		
☐ 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:	
	I _	Dhara
Member/Subscriber Number: Date of Birth:	Fax: Office Contact:	Phone:
Group Number:	NPI:	State Lic ID:
Address:	Address:	State Lie ID.
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name ((if applicable):
*Please note that Envision will process the request as v		
<u> </u>	☐ Expedited/Urg	
Drug Name and Strength:		
Directions (OIO)		
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	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	ted medication:	
☐ Breast cancer (advanced or metastatic)	☐ Other	
Q4. Please select all that apply to this patient:		
☐ The patient is a postmenopausal female		
☐ The patient is a premenopausal or perimenopal	usal female	
☐ The patient's disease is hormone receptor (HR)-positive		
☐ The patient's disease is human epidermal grow	th factor receptor 2 (HE	R2)-negative
☐ The medication will be used in combination with	n an aromatase inhibitor	r for initial endocrine-based treatment
☐ The medication will be used in combination with fulvestrant as initial endocrine based therapy or following		
disease progression on endocrine therapy		
☐ None of the above		
Q5. If the patient's diagnosis is OTHER, please specify	below:	
Q6. Is the patient 18 years of age or older?		
·		



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:
Yes	□No
Q7. Is the requested medication being prescribed by (or i	n consultation 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, plea	ase provide the start date	e (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 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	



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?		
	□ • • •	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):		
*Please note that Envision will process the request as w	ritten, including drug name, wi	th no substitution.	
	☐ Expedited/Urgent		
Drug Name and Strength:			
Directions / CIC.			
Directions / SIG:			
Please attach any pertinent medical history or information	n for this patient that may support	approval. Please answer the	
	estions and sign.	approvan i loudo uniono: inc	
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):		
	,		
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 responded to therapy with a decrease in LDL levels?			
☐ Yes	□ No		



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 ap	plicable):
*Please note that Envision will process the request as w	rritten, including drug nar	ne, with no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Discount of the second of the	. f 4h.! 4! 4! 4	
Please attach any pertinent medical history or information following qu	i for this patient that may su estions 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:	
☐ Hepatocellular carcinoma (unresectable)		
Renal cell carcinoma (advanced)		
☐ Thyroid cancer, differentiated (locally recurrent or me	astatic, progressive)	
☐ Other		
Q4. For RENAL CELL CARCINOMA, will the requested	d medication be used in cor	nbination with everolimus
(Afinitor)?		
☐ Yes	☐ No	
Q5. For RENAL CELL CARCINOMA, has the patient received at least one (1) prior anti-angiogenic therapy?		
Yes	☐ No	
Q6. For THYROID CANCER, is the patient's disease refractory to radioactive iodine?		
☐ Yes	□ No	
Q7. If the patient's diagnosis is OTHER, please specify below:		



Lenvima-1 Medicare

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

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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	ent
Drug Name and Strength:		
Directions / SIG:		
Directions / Gro.		
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 the	rapy
Q2. For CONTINUING THERAPY, please specify the 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 heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.)?		
☐ Yes	☐ No	
Q6. Is the patient pregnant?		
☐ Yes	□No	
Q7. For FEMALE PATIENTS OF CHILD-BEARING POTE	ENTIAL, please select al	I 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 IL	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 request a	s written, including drug	g name, with no substitution.
	☐ Expedited/Urg	gent
Drug Name and Strength:		
D' - 15 1010		
Directions / SIG:		
Please attach any pertinent medical history or informa	tion for this patient that m	av support approval. Please answer the
	questions and sign.	.,,
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing th	nerany
Q2. For continuing therapy, please specify start date	e (MM/YY):	
Q3. Please indicate the diagnosis for which Leukine is	being requested:	
Acute myelogenous leukemia (AML), following inde	uction chemotherapy	
Bone marrow transplant (allogeneic or autologous)	•	elay
Myeloid reconstitution after allogeneic bone marro	•	
Myeloid reconstitution after autologous bone marro	ow transplantation: Non-H	odgkin's lymphoma (NHL), acute
lymphoblastic leukemia (ALL), Hodgkin's lymphoma Peripheral stem cell transplantation: Mobilization a	nd myeloid reconstitution	following autologous peripheral stem cell
transplantation	ma myelola reconstitution	Tollowing datalogodo periprieral sterii deli
☐ Other		
Q4. For AML only, is there excessive (greater than of	or equal to 10%) leukemic	mveloid blasts in the bone marrow or
peripheral blood?	or equal to 1070) leationing	, my ordina bradice in the borne marrow or
☐ Yes		
□ No		
☐ N/A - patient does not have AML		
Q5. If the diagnosis is OTHER, please specify below	v:	



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 ne Leukine (or Neupogen)?	eutropenia in a patient who has received prophylaxis with	
☐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 yeast-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 diabetic peripheral neuropathy, please specify the patient's diagnosis below:		
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	



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/Urgent		
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 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) in children ☐ Other		
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 contraception	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

	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:		
Please attach any pertinent medical history or information following qu	n for this patient that may ıestions and sign.	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, plea	ase provide the start date	(MM/YY):
Q3. Please indicate which medication this request is for:		
Lynparza capsules	☐ Lynparza table	ts
Q4. Please indicate the patient's diagnosis for the reques	ted 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 p	atient:
☐ 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	emotilerapy in the neode	gavant, adjavant, or metastatio setting
Q6. For EPITHELIAL OVARIAN, FALLOPIAN TUBE, (EAL CANCER, has the patient had a
complete or partial response to platinum-based chemotherapy?		



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	erious germline BRCA-mutated (gBRCAm) advanced ovarian
☐ The patient has been treated with three (3) or more prior lines of chemotherapy☐ None of the above	
Q8. If the patient's diagnosis is OTHER, please specify	/ below:
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 metas	<i>'</i>	1)	
☐ 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



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 therapy?			
☐ 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 contractions and sign.	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 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 wh☐ None of the above	
ischemic attack, decompensated heart failure requirin	myocardial infarction, unstable angina, stroke, transient ng hospitalization, or Class III/IV heart failure ee or 3rd degree AV block or sick sinus syndrome, unless
Q7. For GILENYA, will the patient be observed for sign least 6 hours after the first dose?	s and symptoms of bradycardia in a controlled setting for at
_	_
Q8. For GLATIRAMER, is the patient 18 years of age o	<u> </u>
☐ Yes	□ No
Q9. Please indicate the patient's diagnosis for the reques Multiple sclerosis (relapsing forms) First clinical episode and patient has MRI features Other	
Q10. If the patient's diagnosis is OTHER, please specif	fy below:
Prescriber Signature	Date



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

	Certain requests for coverage require review with the prescribing physician. Please number listed above. Please note any information left blank or illegible may delay the
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 appli	cable):
*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 (N	MM/YY).	
and the second s		
Q3. Please indicate the patient's diagnosis for the reques	ted medication:	
	<u></u>	
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	n 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

	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 a	applicable):
*Please note that Envision will process the request as v	written, including drug n	ame, with no substitution.
	☐ Expedited/Urgen	t
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informatio	n 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 thera	any
		эру
Q2. If the request is for CONTINUING THERAPY, plea	ase provide the start date	(MM/YY):
Q3. Please indicate the patient's diagnosis for the reques	sted medication:	
☐ Neurogenic orthostatic hypotension (NOH)	☐ Other	
Tredrogenie orthostatie hypotension (rech)		
Q4. If the patient's diagnosis is OTHER, please specify	y below:	
Q5. If the patient has a diagnosis of NOH, is the NOH du	e to any of the following (r	please select all that apply)?
Primary autonomic failure (Parkinson's disease, m		
Dopamine beta-hydroxylase deficiency	unipie system anopiny, or	pure autoriornic failure)
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	previous question, please specify the
cause of the patient's NOH:		
Q7. Does the patient have any of the following symptoms	s (please select all that ap	oly)?
Orthostatic dizziness		



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



Nucala-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 (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 informat	ion for this natient that may	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. If the request is for CONTINUING THERAPY, plo	ease provide the start date	- (MM/YY)·
Q2. If the request is for continuent of the training in the result of th	odoo provido trio otari date	(Marie 17).
O2 Disease in disease the metional disease six for the assure		
Q3. Please indicate the patient's diagnosis for the reque	ested medication:	
Severe asthma (Add-on maintenance treatment)	• >	
☐ Eosinophilic granulomatosis with polyangiitis (EGPA	4)	
Other		
Q4. For ASTHMA, does the patient have an eosinople	hilic phenotype?	
☐ Yes	☐ No	
	<u> </u>	
Q5. If the patient's diagnosis is OTHER, please spec	city below:	
Q6. Is the patient 12 years of age or older?		
☐ Yes	☐ No	
Q7. Is the requested medication being prescribed by a	pulmonologist or immunol	ogist?
☐ Yes	☐ No	
I and the second		



Nucala-1 Medicare

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

Patient Name:	Prescriber Name:	
Prescriber Signatu	e Date	



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

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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 (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 (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	ne, 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	У
Q2. For continuing therapy, please specify start date (N	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 (\	/IPomas)
☐ 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 ILID or two appropriate contri	racentive methods	
☐ The patient will use an IUD or two appropriate contraceptive methods ☐ N/A - The patient is not female or not of child-bearing potential		
	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



Osphena-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 re	equest as written, including drug i	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 support approval. Please answer the following questions and sign.		
Q1. Is this request for initial or continuing ther	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	
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)?	
Acute thromboembolism or a past history of thromboembolic disease (including patients with a history of DVT, pulmonary embolism, retinal vein thrombosis, stroke, or myocardial infarction)		



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:
☐ Known or suspected estrogen-dependent neoplasia	a
☐ Known or suspected pregnancy	
☐ Vaginal bleeding or dysfunctional uterine bleeding of an undetermined origin	
☐ None of the above	
<u> </u>	
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



PCSK9 Inhibitors-1 Medicare

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

Detient Name:	Dragovikov Namov	
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, w	ith no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Directions / Sig.		
Please attach any pertinent medical history or information	n for this patient that may support	approval. Please answer the
	estions and sign.	approvan riodoc anomor ano
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
O2 For CONTINUING THERADY places enceity the	start data (MM/VV):	
Q2. For CONTINUING THERAPY, please specify the s	start date (IVIIVI/ 1 1).	
Q3. Please indicate which medication this request is for:		
☐ Praluent	Repatha	
Q4. Please indicate the patient's diagnosis for the requested medication:		
	ted medication.	
Heterozygous familial hypercholesterolemia (HeFH)		
☐ Homozygous familial hypercholesterolemia (HoFH)☐ Clinical atherosclerotic cardiovascular disease (CVD)		
· · ·		
☐ Established CVD (to reduce the risk of MI, stroke, cor	oriary revascularization)	
Other		
Q5. For HeFH, has the diagnosis been confirmed by ei	ther of the following?	
☐ Genotyping		
☐ Simon Broome criteria		
☐ None of the above		
O6 For HaEH if the diagnosis was confirmed by Simo	n Broome criteria, places select s	all that apply to this patient:
Q6. For HeFH, if the diagnosis was confirmed by Simon Broome criteria, please select all that apply to this patient:		
☐ Total cholesterol greater than 290 mg/dL		



PCSK9 Inhibitors-1 Medicare

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

Patient Name:	Prescriber Name:	
LDL cholesterol greater than 190 mg/dL Tendon xanthomas in the patient, 1st degree relative (parent, sibling, child), or 2nd degree relative (grandparent, uncle, aunt) DNA-based evidence of LDL receptor mutation, familial defective apo B-100, or PCSK9 mutation None of the above		
Q7. For HoFH, has the diagnosis been confirmed by any of the following? (please select all that apply): 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		
Q8. For CVD, has the patient experienced any of the following (please select all that apply)? 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 be atherosclerotic region None of the above		
Q9. If the patient's diagnosis is OTHER, please specify	below:	
Q10. Please provide the patient's baseline and current LE	DL-C cholesterol levels below:	
Q11. Please indicate the patient's age: Less than 13 years of age 13-17 years of age 18 years of age or older		
Q12. 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 contraindicated or not tolerated by the patient None of the above		
Q13. If statins are contraindicated or not tolerated by the patient, please explain below:		



PCSK9 Inhibitors-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:
Q14. Is the medication being prescribed by (or in consultation Cardiologist Endocrinologist Lipid specialist None of the above	ation with) any of the following?
Q15. For CONTINUING THERAPY, please select all that The patient is tolerating the medication The requested medication will continue to be used Statin therapy is contraindicated or not tolerated by None of the above	in combination with maximally tolerated statin
Prescriber Signature	 Date



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:	none: Specialty/facility name (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 previous treatment for Hepatitis C) ☐ Treatment experienced (i.e. has received treatment for for Hepatitis C 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	☐ 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 select all that apply):		
Decompensated liver disease		
☐ Autoimmune hepatitis☐ Concomitant administration of didanosine with ribavirin 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	



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:	imary 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 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 specify below.			
Q5. Please select all that apply to this patient:			
☐ Patient has received at least two (2) prior therapies 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 relial	ble contraception before,	during and 1 month after initiation of	
therapy			
Patient has been assessed to determine if prophyl	•	botic 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 volume program	willi Pomaiyst RENIS (RIS	sk Evaluation and Mittigation Strategy)	
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 obtained prior to initiation of therapy ☐ Patient will receive pregnancy test monthly during therapy ☐ 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

	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 applications)	able):	
*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 quantum followin	on for this patient that may suppo uestions and sign.	ort approval. Please answer the	
Q1. Is request for initial or continuing therapy?			
☐ Initial therapy	☐ Continuing therapy		
Q2. For continuing therapy, please specify start date (MM/YY):			
Q3. Please indicate the diagnosis for which the requeste	d medication is being prescribe	d:	
☐ Idiopathic thrombocytopenic purpura (ITP)			
☐ Hepatitis C infection associated thrombocytopenia			
 ☐ Severe aplastic anemia with insufficient response to immunosuppressive therapy ☐ Other 			
Q4. If the patient's diagnosis is OTHER, please specify below:			
Q5. Has the patient been evaluated for other causes of the intolerance to corticosteroids, immunoglobulins, or splene	• •	an insufficient response or	
☐ Yes			
Q6. Is the platelet (Plt) count at time of diagnosis: less than 30,000/mcL OR less than or equal to 50,000/mcL with significant mucous membrane bleeding or risk factors for bleeding?			
☐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 regu	ularly throughout therapy?	
☐Yes	□ No	
Q8. Are alanine aminotransferase levels greater than or equal to 3 times the upper limit of normal with any of the following characteristics: progressive, persistent, accompanied by increased bilirubin or symptoms of liver injury or evidence of hepatic decompensation?		
☐Yes	□ No	
Q9. For CONTINUING therapy: Has the platelet count reshas increased to at least 50,000/mcL)	sponded to Promacta? (Response defined as: Platelet count	
☐ Yes	□ No	
ļ	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 maintain the minimal count needed to reduce the patient's	ove 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-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	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 nationt that ma	v sunnort annroval. Please answer the
	questions and sign.	y support approval. Flease allswer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial Therapy	☐ Continuing Th	nerapy
Q2. For CONTINUING THERAPY please indicate the start date (MM/YY):		
Q3. Please indicate the patient's diagnosis: *		
☐ Mantle cell lymphoma		
☐ Multiple Myeloma		
☐ Transfusion-dependent anemia		
☐ Other		
Q4. For MANTLE CELL LYMPHOMA, has the patie which included bortezomib)?	nt relapsed or progressed	after two (2) prior therapies (one of
☐ Yes	☐ No	
Q5. For MULTIPLE MYELOMA, please select all that	at apply:	
Revlimid will be used in combination with dexamethasone	☐ None of the	above
Q6. For TRANSFUSION-DEPENDENT ANEMIA, is syndromes associated with a deletion 5q cytogeneti abnormalities?		



Revlimid-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. If the patient's diagnosis is OTHER, please specify	below:
Q8. Is the patient enrolled in the Revlimid REMS Progran	า?
☐Yes	□ No
Q9. Is the patient pregnant?	
☐Yes	□ No
Q10. 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
Q11. Will the patient be monitored for signs and symptom	ns of thromboembolism?
☐Yes	□ No
Prescriber Signature	



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/Urgent	
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 peritoneal cancer (deleterious germline and/or somatic BRCA mutation associated)		
Epithelial ovarian, fallopian tube, or primary peritoneal cancer (recurrent) 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 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 laboratory 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 standard cytarabine and daunorubicin induction and cytarabine		
consolidation chemotherapy		
☐ None of the above		
Q5. If the patient's diagnosis is OTHER, please specify 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 v	with a strong CYP3A inhibitor (such as clarithromycin or ketoconazo	ole)?
☐ Yes	□No	
Q9. Will Samsca be initiated or re-initiated	d in 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 following que	ı 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 start date (M	1M/VV)·	
Q2. For continuing therapy, please specify start date (iv	11417 1 1).	
O2 Disease indicate the national diagnosis for the various	and mandination.	
Q3. Please indicate the patient's diagnosis for the request		
☐ 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	n or by Donnler echocardicaram it	Enationt is unable to
undergo a right heart catheterization (e.g., patient is frail,	,	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 nam	e (if applicable):
*Please note that Envision will process the request as v	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	n for this patient that	may support approval. Please answer the
	estions and sign.	,
Q1. Is this request for initial or continuing therapy?		
	Continuing	thorony
☐ 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:	Thore.
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 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 Somatu	ine 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

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	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.	y support approval. Please answer the
Q1. Is this request for initial or continuing thera	ару?	
☐ Initial therapy	☐ Continuing the	erapy
Q2. For continuing therapy, please specify s	start date (MM/YY).	
Q3. Please indicate the patient's diagnosis for	the requested medication: *	
☐ Chronic myeloid leukemia (CML) in chronic ☐ Chronic myeloid leukemia (CML) in chronic chromosome-positive (Ph+)	· ·	
☐ Acute lymphoblastic leukemia (ALL), Philad ☐ Other	delphia chromosome-positive (Ph+)
Q4. If the patient's diagnosis is OTHER, ple	ase specify below:	
Q5. Has the patient had resistance or intolerar	nce to prior therapy?	
☐ Yes	□No	
Q6. If yes, did the prior therapy include imat	inib (Gleevec)?	
Yes	□No	
Q7. Is the medication being prescribed by an o	oncologist?	



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:
☐ Yes	□No
Prescriber Signatu	ure 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:	01.1.1.10
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/Urgent		
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

	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 app	olicable):
*Please note that Envision will process the request as v	written, including drug nan	ne, 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 su	pport approval. Please answer the
	uestions and sign.	
O1 le this request for initial or continuing therapy?		
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):		
Q3. Please indicate the patient's diagnosis below: *		
☐ Progressive, well-differentiated pancreatic neuroendo	ocrine tumors in a patient wit	h unresectable 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, ha Gleevec (imatinib)?	s the patient had disease pr	ogression on or intolerance to
☐ Yes	□No	
Q6. Is the patient 18 years of age or older?		
☐ Yes	□No	



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:	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 nam	e, 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 sup estions and sign.	port approval. Please answer the
Tollowing qu	estions and sign.	
O1 to this request for initial or continuing therapy?		
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 (MN	//YY):
	,	,
Q3. Please indicate the patient's diagnosis below:		
	al	
☐ Malignant Melanoma with microscopic or gross nod involvement	al ☐ Other	
involvement		
Q4. If the diagnosis is OTHER, please specify:		
Q5. Does the patient have any of the following (please se	lect all that apply)?	
☐ Autoimmune hepatitis	, , , , , , , , , , , , , , , , , , ,	
Hepatic decompensation (Child-Pugh score greate	r than 6 (Class B or C1)	
None of the above	t than o [oldoo B of o])	
_		
Q6. For melanoma with microscopic or gross nodal involv	•	d as adjuvant treatment within
84 days of definitive surgical resection, including complete		
☐ 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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	Thorie.
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 dru	g name, with no substitution.
	☐ Expedited/Ur	gent
Drug Name and Strength:		
Directions / SIG:		
Directions / Gree.		
Please attach any pertinent medical history or inf		ay support approval. Please answer the
follo	owing questions and sign.	
Q1. Is this request for initial or continuing therapy	?	
☐ Initial therapy	☐ Continuing the	nerapy
Q2. If the request is for CONTINUING THERAF	PY, please provide the start da	ate (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 helow:	
Q4. If the patient's diagnosis is Official, piease	s specify below.	
Q5. Please select if any of the following apply to t	his patient:	
☐ The patient is homozygous for the F508del	mutation	
☐ The patient has a mutation in the cystic fibr		ince regulator (CFTR) gene that is
responsive to tezacaftor/ivacaftor verified by a FI		, , ,
☐ None of the above		
Q6. Is the patient 12 years of age or older?		
☐ Yes	□No	



Fax back to: 877-503-7231

EOC ID:

Phone: 800-361-4542

Symdeko-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 Signatu	e 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 inadequate glycemic control (HbA1c greater than 7% but less than 9%)?		
☐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 and act upon the signs or symptoms of hypoglycemia) ☐ Severe hypoglycemia that required assistance during the past 6 months ☐ The patient requires drug therapy to stimulate gastrointestinal motility ☐ 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 information for this patient that may support approval. Please answer the following 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 THERAPY, please provide the start date (MM/YY):		
Q3. Please indicate the patient's diagnosis for t	the requested medication:	
☐ Melanoma (unresectable or metastatic) in a ☐ Melanoma (unresectable or metastatic) in p trametinib [Mekinist])	·	, , ,
☐ Non-small cell lung cancer, Metastatic with	BRAF V600E mutation, in combination	ation with trametinib
☐ Anaplastic thyroid carcinoma, Locally advaltrametinib☐ Other	nced or metastatic, with BRAF V60	00E mutation, in combination with
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/Urgent		
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information	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?		
	□ o :: : ::	
Initial therapy	☐ Continuing t	nerapy
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:	
☐ 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:**



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/Urgent		
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		
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



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:	
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	name, with no substitution.
	☐ Expedited/Urg	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or i	nformation for this patient that ma llowing questions and sign.	y support approval. Please answer the
Q1. Is this request for initial or continuing therap	py?	
☐ Initial therapy ☐ Continuing therapy		
Q2. For CONTINUING THERAPY, please indicate Start Date (MM/YY):		
Q3. Please indicate the patient's diagnosis belo	w:	
☐ Hypogonadism		
☐ Deficiency or absence of endogenous testo☐ Other	sterone	
Q4. If the patient's diagnosis is OTHER, plea	se specify 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 breast cancer		
☐ None of the above		
Q6. Please indicate the patient's testosterone le	evel PRIOR to start of therapy:	
Total testosterone GREATER than 300 ng/o	dL, free or bioavailable testostero	ne GREATER than 5 ng/dL
☐ Total testosterone LESS than 300 ng/dL, free or bioavailable testosterone LESS than 5 ng/dL		



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/Urgent		
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 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 th	erapy
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 that Thalomid be used as monotherapy?	nodosum leprosum and als	so has moderate to severe neuritis, will



Thalomid-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:
☐ 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 potential been instructed on the importance of proper utilization of appropriate contraceptive methods?	
☐Yes	□No
Q11. Is the patient 12 years of age or older?	
☐Yes	□No
Prescriber Signature	Nate



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 eather	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 Oxologou pilot to thorapy und



Tracleer-6 Medicare

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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



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:	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 informati	on for this nationt that may	support approval. Please answer the		
	questions and sign.	support approval. I lease 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 THERM 1, pie	case provide the start date	(IVIIVII I I).		
	atad a district			
Q3. Please indicate the patient's diagnosis for the reque				
☐ Osteoporosis ☐ Other				
Q4. If the patient's diagnosis is OTHER, please specify 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 factors for fracture (please select all that apply)?				
☐ Advanced age	☐ Rheumatoid a	rthritis		



Tymlos-4 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:
☐ 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:		
Group Number:	NPI:	State Lic ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Primary Phone:	rimary Phone: Specialty/facility name (if applicable):		
*Please note that Envision will process the request as w	vritten, including drug	name, with no substitution.	
	☐ Expedited/Urg	gent	
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.	ay support approval. Please answer the	
<u> </u>			
Q1. Is this request for initial or continuing therapy?			
☐ Initial therapy	☐ Continuing th	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	ted medication:		
☐ Pulmonary arterial hypertension (PAH) (WHO Group I) ☐ Other			
Q4. If the patient's diagnosis is OTHER, please specify	below:		
Q5. Has the patient's diagnosis been confirmed by right h	eart catheterization?		
☐ Yes	☐ No		
Q6. Has the patient tried and had an insufficient response	e to at least one other F	PAH agent (e.g. sildenafil)?	
☐ Yes	☐ No		
Q7. Is the patient 18 years of age or older?			
	□ N-		
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



Venclexta-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:	THORE.	
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	e request as written, including drug na	nme, with no substitution.	
	☐ Expedited/Urgent		
Drug Name and Strength:			
Directions / SIG:			
Please attach any pertinent medical histor	ry or information for this patient that may s following questions and sign.	upport approval. Please answer the	
	th a result O		
Q1. Is this request for initial or continuing t	_		
☐ Initial therapy	☐ Continuing thera	ру	
Q2. For continuing therapy please indicate the start date: (MM/YY)			
Q3. Please indicate the patient's diagnosis	s for the requested medication: *		
☐ Chronic lymphocytic leukemia (CLL)			
☐ Small lymphocytic lymphoma			
☐ Other			
Q4. If the patient's diagnosis is OTHER, please specify:			
Q5. Does the patient have 17p deletions?			
☐ Yes	□No		
Q6. Has the patient received at least one ((1) prior therapy?		
☐ Yes	□No		



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:	
Prescriber Signature	Date	



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 patients dispussible OTHER places are sifetimeters.		
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)-positive		
☐ The patient's disease is human epidermal growth factor receptor 2 (HER2)-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)	
☐ Verzenio will be used as initial endocrine-based treatment in combination with an aromatase inhibitor		
The patient'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		. Isranio or raoquii



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 consultation with) an oncologist?		
☐ Yes	□ No	
Q8. Is the patient 18 years of age or older?		
☐ Yes	□ No	
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-positive		
☐ Other		
Q4. If diagnosis is OTHER, please specify below:		
Q5. Is the prescribing physician an oncologist?		
☐ Yes	☐ No	
		



Xalkori-1 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 Na	me:
	·	
Prescriber Signature		 Date



Xeljanz-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 (i	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:		
Please attach any pertinent medical history or in follo	formation 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. If the request is for CONTINUING THERA	PY, please provide the start date	e (MM/YY):
Q3. Please indicate the patient's diagnosis for the	e requested medication:	
☐ Rheumatoid arthritis (moderately to severely	active)	
☐ Psoriatic Arthritis		
☐ Ulcerative Colitis		
☐ Other		
Q4. FOR Ulcerative Colitis: Is the patient cortic without a return of the symptoms of UC)?	costeroid dependent (ie, an inab	ility to successfully taper corticosteroids
☐ Yes	□No	
Q5. If the patient's diagnosis is OTHER, please	e specify below:	
Q6. Has the patient had failure, contraindication, Methotrexate Enbrel (etanercept) Humira (adalimumab)	or intolerance to any of the follo	wing? (please select all that apply):



Xeljanz-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:
☐ 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	s listed in the previous question, is there a reason these pry 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 A biologic DMARD (such as Enbrel (etanercept), H (golimumab)) A potent immunosuppressant (such as azathioprine None of the above	lumira (adalimumab), Cimzia (certolizumab), Simponi
Q10. Is the requested medication prescribed by (or in cor	nsultation with) a rheumatologist or gastroenterologist?
Droopile or Circophure	Date
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:	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:		
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 bisphos	-	,
☐ Prevention of skeletal related events in patients with		
☐ 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 requeanswer the following questions and fax this form to the number listed a review process.	ests for coverage require review with the prescribing physician. Please above. Please note any information left blank or illegible may delay the
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 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 information following of	on for this patient that ma juestions and sign.	ay support approval. Please answer the
	, .	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing th	erany
Q2. If the request is for CONTINUING THERAPY, ple	ease provide the start da	te (MM/YY):
Q3. What is the patient's diagnosis for the requested me	edication? *	
☐ Chronic idiopathic urticaria		
☐ Moderate to severe persistent allergic asthma		
Other		
Q4. FOR URTICARIA, does the patient remain sympt	tomatic desnite H1 antihi	istamine treatment?
	<u></u>	Starring treatment:
Yes	☐ No	
Q5. FOR CONTINUING THERAPY: Has a demonstra	ated improvement in asth	nma control been noted?
☐ Yes	☐ No	
OO FOR ACTUMA also a sale of all the described with		
Q6. FOR ASTHMA, please select all that apply to this	•	
Patient has evidence of specific allergic sensit		, , , , , , , , , , , , , , , , , , , ,
blood test (i.e. radioallergosorbent test) for a specific Pretreatment serum IgE levels are greater tha	•	
☐ Patient's symptoms are not adequately control		
beta2-agonist (LABA) for at least 3 months OR men	=	
Julian agomet (E. 15. 1) for at loade o months of them		S.S.S. S. CO CO CO LA LOT CONTINUIDO



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



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

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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	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 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 ther	ару
Q2. For CONTINUING THERAPY, please provide the	start date (MM/YY):	
q2.1 of Gottimonto There is 1, ploado provido ino	otare dato (WWW 11).	
O3 Please indicate the nationt's diagnosis for the reques	sted medication below:	
Q3. Please indicate the patient's diagnosis for the requested medication below:		
Prostate Cancer (metastatic, castration-resistant)	Other	
Q4. If the patient's diagnosis is OTHER, please specif	y below:	
Q5. Will the requested medication be used in combinatio	n with methylprednisolone	27
Yes	☐ No	
Q6. Has the patient tried and failed (or has an intolerance	e or contraindication to) Z	ytiga?
☐ Yes	□No	
Q7. Is the patient 18 years of age or older?		
☐ Yes	☐ No	
Q8. Is the medication being prescribed by (or in consulta	tion with) an oncologist or	urologist?
25. 15 the medication being probeinged by (or in contents		



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 Signat	ture	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	pecify 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 enseith	, 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 Name	»:
Prescriber Signature	_	Date