

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



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Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process.

**Patient Name: Prescriber Name:** 



Adempas-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 req	quest as written, including drug	name, with no substitution.	
☐ Expedited/Urgent			
Orug Name and Strength:			
Directions / SIG:			
Please attach any pertinent medical history or i	information for this patient that ma	y support approval. Please answer the	
Q1. Is this request for initial or continuing therap	py?		
☐ Initial therapy	☐ Continuing the	erapy	
Q2. For CONTINUING THERAPY, please pr	ovide the start date (MM/YY):		
Q3. Please indicate the patient's diagnosis for t	he requested medication: *		
<ul><li>☐ Chronic thromboembolic pulmonary hype</li><li>☐ Pulmonary arterial hypertension (PAH) W</li><li>☐ Other</li></ul>	, ,		
Q4. For CTEPH, please select if any of the fo	ollowing apply to this patient:		
☐ The patient has persistent or recurren☐ The patient's condition is inoperable☐ None of the above	nt disease after surgical treatment	(such as pulmonary endarterectomy)	
Q5. For PAH, was the diagnosis confirmed b	y right heart catheterization?		
☐ Yes	□No		
Q6. If the patient's diagnosis is OTHER, plea	se specify below:		
Q7. Is the patient at least 18 years of age or old	der?		



Adempas-5 Medicare

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Patient Name:	Prescriber Name:	
☐ Yes	□No	
Q8. For FEMALE patients, is the patient enrolled in the A  Yes  No N/A - the patient is not female	DEMPAS REMS program?	
Q9. Is Adempas being prescribed by (or in consultation w	rith) a pulmonologist or cardiologist?	
☐ Yes	□ No	
Prescriber Signature		Date



ADHD-2 Medicare

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

Patient Name:	Prescriber Name:	
-		Di
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact: NPI:	State Lie ID:
Group Number: Address:	Address:	State Lic ID:
City, State ZIP:	City, State ZIP:	
•		f annlicable):
Primary Phone: Specialty/facility name (if applicable):		
*Please note that Envision will process the reque	<u>_</u>	•
□ Expedited/Urgent		ent
Drug Name and Strength:		
Directions / SIG:		
Birections / Gro.		
Please attach any pertinent medical history or info	ormation for this patient that may	v support approval. Please answer the
	wing questions and sign.	, capport approvant react another and
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	erapy
Q2. If the request is for CONTINUING 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	
	<del></del>	



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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 ar	MAOI concurrently with the	ne requested medication, or within the last 14 days?	
☐ Yes		□No	
Q10. Is the prescriber a psyddrugs?	chiatrist with experience pr	escribing both MAOI and amphetamine/dextroamphetamine	
☐ Yes		□ No	
Prescriber Si	gnature	Date	



Alecensa-3 Medicare

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

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



Alecensa-3 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:
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?	<b>)</b>		
		orony	
☐ Initial therapy	☐ Continuing the	егару	
Q2. If the request is for CONTINUING THERAF	Y, please provide the start date	e (MM/YY):	
Q3. Please indicate the patient's diagnosis for the	requested medication:		
☐ Alpha-1-antitrypsin (AAT) deficiency	☐ Other		
Q4. If the patient's diagnosis is OTHER, please	specify below:		
Q5. Is the patient 18 years of age or older?			
☐ Yes	☐ No		
Q6. Please select all that apply for this patient:			
☐ The alpha1-proteinase inhibitor concentration	on is less than 11 micromoles r	ner liter	
☐ The patient's FEV1 level is between 35% ar	·		
☐ The patient's FEV1 level is greater than 60%	•		
None of the above	p. Galotoa		
Q7. IF THE FEV1 IS GREATER THAN 60% PR		erienced a rapid decline in lung function	
(i.e., reduction of FEV1 more than 120 mL/year	) that warrants treatment?		



Alpha-1 Proteinase Inhibitor-1 Medicare

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



Alunbrig-3 Medicare

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

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



Alunbrig-3 Medicare

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□ No



Analeptics-3 Medicare

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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 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 therapy			
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 to ☐ The patient experiences excessive sleepiness to ☐ None of the above	
Q8. If the patient's diagnosis is OTHER, please specify	y below:
Prescriber Signature	Date



Arcalyst-2 Medicare

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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
	<del>-</del>	
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:** 

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Arcalyst-2 Medicare

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Prescriber Signature

Date



Arikayce-1 Medicare

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

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



Arikayce-1 Medicare

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Patient Name:	Prescriber Name:
☐ Yes	□No
Q9. Is the requested medication being prescribed by (or i pulmonologist?	n consultation with) an infectious disease specialist or
☐ Yes	□ No
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	
	<b></b>	
Q6. Is the patient 18 years of age or older?		
☐ Yes	☐ No	
I		



Prescriber Signature

**EOC ID:** 

Auryxia-1 Medicare

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Date



Austedo-1 Medicare

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

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



Austedo-1 Medicare

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Patient Name:	Prescriber Name:
Q8. Is the requested medication being prescribed by (or i	n 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 therapy		
Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):		
,		,
Q3. Please indicate the patient's diagnosis for the 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

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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



Braftovi-3 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if	applicable):
*Please note that Envision will process the request as	written, including drug ı	name, with no substitution.
	☐ Expedited/Urge	nt
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information	on for this natient that may	support approval. Please answer the
	uestions and sign.	Support approval. I lease allower the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	гару
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):		
, , , , , , , , , , , , , , , , , , , ,	(	
Q3. Please indicate the patient's diagnosis for the reques	sted medication:	
Melanoma (unresectable or metastatic)	Other	
Q4. If the patient's diagnosis is OTHER, please specify b	pelow:	
Q5. Does the patient have BRAF V600E or V600K mutat	tion as detected by an FD	A-approved test?
☐ Yes	□ No	••
Q6. Will Braftovi be used in combination with Mektovi (bi	nimetinib)?	
☐ Yes	□No	
	in concultation with) on a	annint?
Q7. Is the requested medication being prescribed by (or		icologist?
Yes	☐ No	
Q8. Is the patient 18 years of age or older?		
<u> </u>		



Prescriber Signature

**EOC ID:** 

Braftovi-3 Medicare

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Date



Cabometyx-3 Medicare

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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process.

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (i	f applicable):
*Please note that Envision will process the red	quest as written, including drug	name, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
D: 1: 1010		
Directions / SIG:		
Please attach any pertinent medical history or		y support approval. Please answer the
fc	ollowing questions and sign.	
Q1. Is this request for initial or continuing thera	py?	
☐ Initial therapy	☐ Continuing the	erapy
Q2. If the request is for CONTINUING THER	RAPY, please provide the start date	e (MM/YY):
·		
Q3. Please indicate the patient's diagnosis for t	the requested medication:	
☐ Renal cell carcinoma (advanced)	☐ Other	
Q4. If the patient's diagnosis is OTHER, plea	ase specify below:	
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
Q5. Is the patient 18 years of age or older?		
☐Yes	□No	
Prescriber Signature		Date



Calquence-3 Medicare

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

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



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 national to the nation	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 requested 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 lungs as confirmed by cultures of the airways?		



Cayston-1 Medicare

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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process.

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



Copiktra-4 Medicare

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

Patient Name:	Prescriber Name:		
Member/Subscriber Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Group Number:	NPI:	State Lic ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Primary Phone:	Specialty/facility name (if ap	pplicable):	
*Please note that Envision will process the request as v	written, including drug na	me, with no substitution.	
	☐ Expedited/Urgent		
Drug Name and Strength:			
Directions / SIG:			
Please attach any pertinent medical history or informatio	on for this patient that may su	ipport approval. Please answer the	
	uestions and sign.	apport approval. I loade allower and	
Q1. Is this request for initial or continuing therapy?			
☐ Initial therapy	☐ Continuing therap	ру	
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):			
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,		
Q3. Please indicate the patient's diagnosis for the reques	sted medication:		
Chronic lymphocytic leukemia/small lymphocytic lymphoc		or refractory	
Follicular lymphoma, relapsed or refractory	priorita (OLL/OLL), relapseu	Tor remactory	
Other			
Q4. If the patient's diagnosis is OTHER, please specifi	y below:		
Q5. Has the patient been treated with at least 2 prior therapies?			
☐ Yes	☐ No		
Q6. Is the requested medication being prescribed by (or in consultation with) an oncologist or hematologist?			
☐ Yes	□ No		
Q7. Is the patient 18 years of age or older?			
☐ Yes	☐ No		



Copiktra-4 Medicare

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

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



Corlanor-2 Medicare

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

Patient Name:	Prescriber Name:		
Member/Subscriber Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Group Number:	NPI:	State Lic ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Primary Phone:	Specialty/facility name	(if applicable):	
*Please note that Envision will process the request as	s 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, pl	lease provide the start dat	te (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 specify below:			
Q5. Is the patient's left ventricular ejection fraction (LVEF) 35% or less?			
☐ Yes	□No		
Q6. Is the patient in sinus rhythm with resting heart rate of 70 beats per minute 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 degree AV block (unless a functioning demand pacemaker is		
present)		
☐ Bradycardia (i.e. resting heart rate is less than 60 beats per minute prior to treatment)		
☐ None of the above		
Prescriber Signature	Date	



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, 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 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 mutat	ion?		
Yes	□ No		
Q6. Will the requested medication be used in combination 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



Dalfampridine-2 Medicare

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

Patient Name:	Prescriber Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Group Number:	NPI:	State Lic ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Primary Phone:			
*Please note that Envision will process th	he request as written, including drug n	ame, with no substitution.	
	☐ Expedited/Urgen	ıt	
Orug Name and Strength:			
Directions / SIG:			
Directions / Sig.			
Please attach any pertinent medical histo	ory or information for this patient that may	support approval. Please answer the	
<u> </u>	following questions and sign.		
Q1. Is this request for initial or continuing	therapy?		
☐ Initial therapy	☐ Continuing there	ару	
Q2. For CONTINUING THERAPY, plea	ase specify the start date (MM/YY):		
Q3. Please indicate the patient's diagnosi	s for the requested medication: *		
☐ Multiple sclerosis (MS)	☐ Other		
Q4. If the patient's diagnosis is OTHER	R, please specify below:		
Q5. Has patient demonstrated sustained assistance) prior to starting the medication	•	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 pre	escribed by (or in consultation with) a neu	rologist?	
☐ Yes	☐ No		
Q8. Does the patient have any of the follo	wing (please select all that apply)?		



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



Daurismo-1 Medicare

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

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



Daurismo-1 Medicare

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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process.

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



Diclofenac Topical-2 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (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:	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	erapy		
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 chemotherapy 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 GOTTINGING 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 specify 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 immur	nosuppressant (such as a	zathioprine 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 for at least 3 consecutive months	s (such as methotrexate, cyclosporine, acitretin, sulfasalazine)
☐ None of the above	
Q7. For PLAQUE PSORIASIS, does the patient's disease crucial body areas such as the hands, feet, face, or genit	e affect more than 5% of the body surface area (BSA) or affect als?
☐ Yes	□ No
Q8. Please indicate the patient's age below:	
Under 2 years	
2-3 years	
☐ 4-17 years	
☐ 18 years or older	
Prescriher Signature	Date



Endari-3 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (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 specif	fy 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 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



Entresto-2 Medicare

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

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



Entresto-2 Medicare

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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process.

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



Epidiolex-1 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (	if applicable):
Please note that Envision will process the	request as written, including drug	name, with no substitution.
	☐ Expedited/Urg	ent
Orug Name and Strength:		
Directions / SIG:		
medions / Sig.		
Please attach any pertinent medical history	or information for this patient that ma following questions and sign.	y support approval. Please answer the
Q1. Is this request for initial or continuing the	erany?	
	_	
☐ Initial therapy	Continuing the	erapy
Q2. For CONTINUING THERAPY, please	e provide the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis f	or the requested medication:	
☐ Severe myoclonic epilepsy in infancy		
☐ Lennox-Gestaut syndrome (LGS)		
☐ Other		
Q4. Is the patient 2 years of age or older?	<u> </u>	
☐ Yes	□No	
Q5. If the patient's diagnosis is OTHER, p	lease specify below:	
Q6. Is the requested medication being preso	cribed by (or in consultation with) a ne	eurologist?
☐ Yes	□ No	
<u> </u>		
Prescriber Signature		Date



Epidiolex-1 Medicare

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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process.

Patient Name:	Prescriber Name:



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 unover 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 ITE ITE 1, place speelly allow	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	<del>-</del>	<u> </u>
CKD not on dialysis, or cancer); 11 g/dL (CKD on dialysis	s); or 12 g/dL (pediatric CKD)?	<b>?</b>
☐ 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 requesanswer the following questions 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



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	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 informat	tion for this nationt that may	sunnort annroval Please answer the		
	questions and sign.	support approval. I lease allower the		
Q1. Is this request for initial or continuing therapy?				
☐ Initial therapy	☐ Continuing the	гару		
Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):				
, p	()			
Q3. Please indicate the patient's diagnosis for the requ	ested medication:			
☐ Multiple myeloma	☐ Other			
Q4. If the patient's diagnosis is OTHER, please spec	cify below:			
Q5. Is the patient 18 years of age or older?				
	□No			
Yes	□ No			
Q6. Will Farydak be used in combination with bortezon	nib (Velcade) and dexametl	hasone?		
☐ Yes	☐ No			
Q7. Has the patient received at least two (2) prior regin agent [eg, Revlimid (lenalidomide), Thalomid (thalidom	_	(Velcade) and an immunomodulatory		
☐ Yes	□ No			
Q8. Is the requested medication being prescribed by (c	or in consultation with) an o	ncologist/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

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 i	name, with no substitution.	
	☐ Expedited/Urge	nt	
Drug Name and Strength:			
Directions / SIG:			
Diagonal de la composição de la composiç	f 41		
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	rapy	
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	Other		
patient)	☐ Other		
Q4. If the patient's diagnosis is OTHER, please specif	v below.		
a m and passence alagnosis is a milery, produce openin	y 20.011.		
OF to the coefficient 40 conserve of a second day 0			
Q5. Is the patient 16 years of age or older?			
Yes	☐ No		
Q6. If the patient is taking any strong or moderate cytocy	rome P450 (CYP450) 3A	4 inhibitors, (such as aprepitant,	
clarithromycin, diltiazem, erythromycin, fosamprenavir, fluconazole, itraconazole, ketoconazole, nefazodone, nelfinavir,			
ritonavir, verapamil) will they be monitored or have dosin	ig adjustments made if ne	ecessary?	
☐ Yes			
□No			
☐ N/A - Patient is not taking any strong CYP450 3A4 ir	hibitors		
Q7. The plan has the following quantity limits in place: 120 lozenges per 30 days. Will the patient require a quantity			
The process of the second of t		and parameter 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:	uires a quantity greater than specified above, please provide rationale for a quantity limit		
Prescriber Signature			



Filgrastim-3 Medicare

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

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



Filgrastim-3 Medicare

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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process.

Patient Name:	Prescriber Name:
(or Leukine) OR in patients at risk for infection-related  ☐ 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



Firdapse-1 Medicare

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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process.

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (	if applicable):
*Please note that Envision will process the request a	as written, including drug	name, with no substitution.
	☐ Expedited/Urg	ent
Drug Name and Strength:		
Directions / SIG:		
Silection of Gree.		
Please attach any pertinent medical history or information		y support approval. Please answer the
following	g questions and sign.	
Q1. Is this request for initial or continuing therapy?		
	<b>□ ○</b> " · "	
☐ Initial therapy	☐ Continuing the	erapy
Q2. For CONTINUING THERAPY, please provide to	the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the req	uested medication:	
☐ Lambert-Eaton myasthenic syndrome (LEMS)	☐ Other	
Q4. If the patient's diagnosis is OTHER, please spe	ecify helow:	
Q4. If the patient's diagnosis is 3 ffilery, piedoe spe	cony below.	
Q5. Is the patient 18 years of age or older?		
	□ N.	
Yes	☐ No	
Q6. Does the patient have a history of seizures?		
☐ Yes	□No	
_	<del>_</del> -	
Prescriber Signature		Date

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Firdapse-1 Medicare

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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process.

**Patient Name: Prescriber Name:** 

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Forteo-4 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (i	f applicable):
*Please note that Envision will process the reque	est as written, including drug	name, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or info	ormation for this patient that may wing questions and sign.	y support approval. Please answer the
Q1. Is this request for initial or continuing therapy?	?	
☐ Initial therapy	☐ Continuing the	erapy
Q2. For CONTINUING THERAPY, please spec	ify the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the	requested medication: *	
Osteoporosis (glucocorticoid-induced)		
Osteoporosis (primary or hypogonadal)		
☐ Osteoporosis (postmenopausal)		
☐ Other		
Q4. If the patient's diagnosis is OTHER, please	specify below:	
Q5. Has the patient experienced a prior fragility fra	acture?	
☐ Yes	☐ No	
Q6. Has the patient had an inadequate response to contraindication or intolerance to a bisphosphonat		sphonate (one year), OR has a
☐ Yes	☐ No	
Q7. Does the patient have any of the following risk	c factors for fracture (please sel	ect all that apply)?



Forteo-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:	
☐ Advanced age ☐ Parental history of fracture ☐ Low body mass index (BMI) ☐ Current smoker ☐ Chronic alcohol use	☐ Rheumatoid arthritis ☐ Chronic steroid use ☐ Other secondary cause of Osteoporosis ☐ None of the above	
Prescriber Signature	Date	



Galafold-2 Medicare

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

Patient Name:	Prescriber Name:		
Member/Subscriber Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
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		pproval. Please answer the	
following qu	estions and sign.		
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:		
☐ Fabry disease	Other		
Q4. If the patient's diagnosis is OTHER, please specify below:			
a and patients alagnosis is aa. i, please speein,			
Q5. Does the patient have an amenable galactosidase al	pha gene (GLA) mutation?		
☐ Yes	□No		
Q6. Is the patient 18 years of age or older?			
☐ Yes	□No		



Galafold-2 Medicare

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

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



Gilotrif-2 Medicare

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

Patient Name:	Prescriber Name:		
Member/Subscriber Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Group Number:	NPI:	State Lic ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Primary Phone:	Specialty/facility name (if a	pplicable):	
*Please note that Envision will process the request as v	vritten, including drug na	ame, with no substitution.	
	☐ Expedited/Urgent	t	
Drug Name and Strength:			
Directions / SIG:			
Please attach any pertinent medical history or information 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 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–small cell lung cancer (NSCLC), metastatic			
Non-small cell lung cancer (NSCLC), metastatic squamous (previously treated)			
Other			
O4. Has the nationt's disease progressed following pla	tinum-hased chemotheran	nv?	
Q4. Has the patient's disease progressed following platinum-based chemotherapy?			
Yes	☐ No		
Q5. If the patient's diagnosis is OTHER, please specify	below:		
Q6. Do the patient's tumors have non-resistant epiderma	Larouth factor recentor (E	CED) mutations as detected by an	
FDA-approved test?	i growiii iacioi receptor (E	or ity illutations as detected by all	
	Пио		
Yes	□ No		
Q7. Is the patient 18 years of age or older?			
☐ Yes	□No		
	<b>—</b> -		



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 Prescriber Signature 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 therapy		
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 become analytics
Growth failure in children	<del></del>	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 CKD, please select all that apply:  Metabolic, endocrine, and nutritional abnormalities have been treated or stabilized  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, please select all that apply:  The patient has a randomly assessed growth hormone (GH) level less than 20 ng/mL  Other causes of hypoglycemia have been ruled out  Other treatments have been ineffective  None of the above		
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	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	ition 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 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 documentation):	HCV RNA level within the last 6 months (must submit
Q9. Please provide the patient's subtype (must submit d	locumentation):
Q10. Please provide the patient's HCV RNA (viral load)	level (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	1?
Q15. Has the prescriber documented the following within AST/ALT, 3) Total Bilirubin, 4) Serum Albumin, 5) PT/IN	
☐Yes	□ No
Q16. For Vosevi: Has the patient previously tried and fair Yes  No N/A - The request is for Mavyret	iled (or had a contraindication or intolerance to) Mavyret?
Prescriber Signature	Date



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:	
Pate of Birth:	Office Contact:		
Group Number:	NPI:	State Lic ID:	
ddress:	Address:		
city, State ZIP:	City, State ZIP:		
rimary 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	
rug Name and Strength:			
Directions / SIG:			
Please attach any pertinent medical history	or information for this patient that may following questions and sign.	y support approval. Please answer the	
	<del>-</del>		
Q1. Is this request for initial or continuing the	rapy?		
☐ Initial	☐ Continuing		
Q2. For continuing therapy, please specify	v start date (MM/YY):		
Q3. Is the patient greater than or equal to 65	years of age?		
☐Yes	□No		
Q4. Please indicate the diagnosis for which t	he requested medication is being pro	escribed:	
Attention deficit hyperactivity disorder (A	DHD)		
Hypertension			
☐ Other			
Q5. If the diagnosis is OTHER, please spe	-:£.		
~~	ecity.		



HRM ADHD-1 Medicare

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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process.

Patient Name:	Prescriber Na	me:
Prescriber Signature		Date



HRM Analgesics-3 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (i	f applicable):
Please note that Envision will process the re	equest as written, including drug	name, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions / CIC.		
Directions / SIG:		
Please attach any pertinent medical history o	r information for this patient that may	v support approval. Please answer the
	following questions and sign.	y support approvant rouge 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 1311	, ,	
Q3. Is the patient greater than or equal to 65	vears of age?	
_ Yes	,	
Q4. Please indicate the diagnosis for which th	ne requested medication is being pre	escribed:
☐ Tension or muscle contraction headache		
Acute Pain		
Osteoarthritis		
Gout		
Ankylosing Spondylitis		
Rheumatoid Arthritis		
☐ Other		



Prescriber Signature

**EOC ID:** 

HRM Analgesics-3 Medicare

Phone: 800-361-4542 Fax back to: 877-503-7231 Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process. **Patient Name: Prescriber Name:** 

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Date



HRM Anti-Arrhythmics-3 Medicare

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

ember/Subscriber Number:  ate of Birth:  oup Number:  Idress:	Fax: Office Contact: NPI: Address:	Phone:
oup Number: dress:	NPI:	
dress:		
	Address:	State Lic ID:
0.1.710	<u> </u>	
ty, State ZIP:	City, State ZIP:	
imary Phone:	Specialty/facility name (if	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

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 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. In 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		



HRM Antidepressants-8 Medicare

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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process. Proscribor Namo: **Patient Name:** 

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



HRM Antiemetics-3 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
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: 11 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:	
Primary Phone:	Specialty/facility name (if a	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:		
Div. 11 (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 t	_	
☐ 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 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 Antiparkinson Agents-4 Medicare

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

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



HRM Antiparkinson Agents-4 Medicare

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

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

Date

Prescriber Signature



HRM Antipsychotics-6 Medicare

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

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



HRM Antipsychotics-6 Medicare

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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process.

Patient Name:	Prescriber Name:
Prescriber Signature	Date



HRM Barbiturates-5 Medicare

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

Patient Name:	Prescriber Name:	Prescriber Name:	
/lember/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	e request as written, including drug	name, with no substitution.	
	☐ Expedited/Urge	ent	
Orug Name and Strength:			
Directions / SIG:			
Please attach any pertinent medical history	y or information for this patient that may following questions and sign.	y support approval. Please answer the	
Q1. Is this request for initial or continuing the	nerapy?		
☐ Initial therapy	☐ Continuing the	erapy	
Q2. For continuing therapy, please speci	ify start date (MM/YY):		
Q3. Please indicate the diagnosis for which	the requested medication is being pre	escribed:	
☐ Seizure Disorder			
☐ Anxiety			
☐ Insomnia			
☐ Other			
Q4. If the diagnosis is OTHER, please sp	pecify below:		
Q5. Is the patient greater than or equal to 6	55 years of age?		
☐ Yes	☐ No		
Q6. FOR PRESCRIBER INFORMATION O (citalopram, escitalopram, fluvoxamine, ser trazodone.		•	



HRM Barbiturates-5 Medicare

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

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



HRM Dementia Agents-4 Medicare

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

Patient Name:	tient 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:		
Sirediction die.		
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 an anagement to a real speed, a 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	sule, 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 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 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 pallation 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

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



HRM Muscle Relaxant-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	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.	y support approval. Please answer the
Q1. Is this request for initial or continuing the large limitial therapy  Q2. If the request is for CONTINUING TH  Q3. Please indicate the patient's diagnosis for large limiting large limiting large limiting large large limiting large	☐ Continuing the ERAPY, please provide the start date or the requested medication:	
☐ Chronic Intermittent Painful Musculosl ☐ Fibromyalgia ☐ Restless Leg Syndrome ☐ Nocturnal Leg Cramps ☐ Other	keletal conditions	
Q4. If the patient's diagnosis is OTHER, p	lease specify:	
Q5. Is the patient greater than or equal to 65	years of age?	
☐Yes	□No	



HRM Muscle Relaxant-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



HRM Oncology-6 Medicare

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

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



HRM Oncology-6 Medicare

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

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



HRM Platelet Inhibitors-4 Medicare

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

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



Fax back to: 877-503-7231

### **EOC ID:**

HRM Platelet Inhibitors-4 Medicare

Phone: 800-361-4542

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



HRM Sedative Hypnotics-7 Medicare

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

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



HRM Sedative Hypnotics-7 Medicare

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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process.

·	
Patient Name:	Prescriber Name:
Prescriber Signature	Date



Humira-1 Medicare

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

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



Humira-1 Medicare

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

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



Humira-1 Medicare

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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process.

Patient Name:	Prescriber Name

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Ibrance-1 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if	fapplicable):
*Please note that Envision will process the	e request as written, including drug	name, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions / CIC.		
Directions / SIG:		
Please attach any pertinent medical history	y or information for this patient that may following questions and sign.	support approval. Please answer the
	ionowing questions and sign.	
Q1. Is this request for initial or continuing the	nerapy?	
☐ Initial therapy ☐ Continuing therapy		
Q2. For CONTINUING THERAPY, please indicate the start date (MM/YY):		
Q3. Please indicate the patient's diagnosis	for the requested medication:	
☐ Breast cancer, advanced or metastatic	(initial endocrine-based therapy)	
☐ Breast cancer, advanced or metastatic ☐ Other	(second-line endocrine-based therapy)	)
Q4. Is the patient a post-menopausal fen	nale?	
☐Yes	□No	
Q5. Did the patient experience disease p	progression following previous endocrin	ne based therapy?
☐Yes	□No	
Q6. If the patient's diagnosis is OTHER,	please specify below:.	
Q7. Is the patient's disease hormone recep negative?	tor (HR)-positive, human epidermal gro	owth 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 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:		
21		
Directions / SIG:		
Please attach any pertinent medical history or information		ay support approval. Please answer the
following qu	estions and sign.	
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:	
Acute lymphoblastic leukemia, Philadelphia chromoso	ome-positive (Ph+ALL)	
☐ Chronic myeloid leukemia (CML) (chronic, accelerate	d, or blast phase)	
☐ Other		
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Please select if any of the following apply to this patie	ent (please select all tha	at anniv):
No other tyrosine kinase inhibitor therapy is indicat		a. app.y).
☐ The patient is T315I-positive	ed for this patient	
None of the above		
Q6. Please indicate the prescriber's specialty below:		
		Other
☐ Hematologist ☐ Oncologist		
Q7. If the prescriber's specialty is OTHER, please spec	cify below:	



Iclusig-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	



Idhifa-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:	, none
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 a	as written, including dru	ug name, with no substitution.
	☐ Expedited/U	Irgent
Orug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informa following	ation for this patient that n g questions and sign.	nay support approval. Please answer the
	<u> </u>	
Q1. Is this request for initial or continuing therapy?		
│ │	☐ Continuing t	therapy
Q2. For CONTINUING THERAPY, please provide the	he start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the requ	uested medication:	
☐ Acute myeloid leukemia (AML), relapsed/refracto	ory	
O4 If the nation's diament is OTUED places and		
Q4. If the patient's diagnosis is OTHER, please spe	сту реюм:	
Q5. Does the patient have an an isocitrate dehydroger	nase 2 mutation as detec	cted by an FDA approved test?
	☐ No	
☐ Yes		
Q6. Is the patient 18 years of age or older?	□ Na	
	□No	
Q6. Is the patient 18 years of age or older?		tologist or oncologist?



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.		he
Patient Name:	Prescriber Name:	
Prescriber Signature	Date	



Imbruvica-1 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
rimary Phone: Specialty/facility name (if applicable):		able):
*Please note that Envision will process the request as w	vritten, including drug name,	with no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions (OIO)		
Directions / SIG:		
Please attach any pertinent medical history or information	n for this patient that may suppo	ort approval. Please answer the
	estions and sign.	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. If the request is for CONTINUING THERAPY, plea	se provide the start date (MM/	YY):
α, μ	(	/.
Q3. Please indicate the patient's diagnosis for the reques	ted medication:	
☐ Chronic graft-versus-host-disease (cGVHD) (after fail		temic therapy)
☐ Chronic lymphocytic leukemia (CLL) with or without 1		ternio trierapy)
☐ Mantle cell lymphoma (MCL) (in patients who have re	•	
☐ Marginal zone lymphoma, relapsed/refractory (in patie		
prior anti-CD20-based therapy)		.,,
☐ Small lymphocytic lymphoma (SLL) with or without 17	p 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:	
		<b>5</b>
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 of stimulation test?	or elevated growth hormo	ne (GH) levels based	on at least one growth hormone
☐ 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:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	Chata Lia ID.
Group Number: Address:	NPI: Address:	State Lic ID:
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (i	f applicable):
*Please note that Envision will process the reques		
Trease note that Envision will process the reques	Expedited/Urge	
Drug Name and Strength:	□ Expedited/Orge	51 IL
3		
Directions / SIG:		
Please attach any pertinent medical history or infor	mation for this patient that maying questions and sign.	y support approval. Please answer the
IOIIOW	ing questions and sign.	
Q1. Is this request for initial or continuing therapy?		
│	☐ Continuing the	erapy
.,	-	
Q2. For CONTINUING THERAPY, please provide	e the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the re	equested medication:	
☐ Non-small cell lung cancer (metastatic)	☐ Other	
Q4. If the patient's diagnosis is OTHER, please s	pecity below:	
Q5. Does the patient have known active epidermal	• • •	•
(L858R) substitution mutations as detected by an F	DA-approved test or Clinical L	aboratory Improvement
Amendments-approved facility?	_	
Yes	☐ No	
Q6. Is the medication prescribed by (or in consultati	on with) 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 due to blood trans	•	
Other		
Q4. If the patient's diagnosis is OTHER,	please specify below:	
Q5. Please indicate the patient's age:		
Under 2 years	☐ 2 years and old	dor.
☐ Officer 2 years		uei
Q6. What is the patient's serum creatinine le	evel?	
Q7. What is the patient's serum ferritin level	?	
Q8. Is the requested medication prescribed	by a hematologist?	
	<u> </u>	<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

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/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical hist	tory 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	
Q2. For continuing therapy, please sp	ecify start date (MM/YY):	
Q3. Please indicate the diagnosis for wh	ich Itraconzole is being requested: *	
Systemic fungal infection (e.g., as	pergillosis, histoplasmosis, blastomycosis	)
Onychomycosis	, -	•
☐ Candidiasis (esophageal or oroph	aryngeal) that is refractory to treatment wi	th fluconazole (ORAL SOLUTION
ONLY)		
☐ Other		
Q4. If the diagnosis is OTHER, please	e specify below:	
Q5. For ONYCHOMYCHOSIS, has the control preparation, fungal culture, or nail biopsy	diagnosis has been confirmed with a funga	al diagnostic test (e.g., KOH
☐ Yes	□No	
Prescriber Signature		Date



Itraconazole-1 Medicare

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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process.

**Patient Name: Prescriber Name:** 



IVIG-1 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name	(if applicable):
*Please note that Envision will process the requ	est as written, including drug	g name, with no substitution.
	☐ Expedited/Urg	gent
Drug Name and Strength:		
D' 1' 1010		
Directions / SIG:		
Please attach any pertinent medical history or inf	ormation for this patient that ma	ay support approval. Please answer the
folic	wing questions and sign.	
Q1. Is the request for initial or continuing therapy	· · · · · · · · · · · · · · · · · · ·	
☐ Initial therapy ☐ Continuing therapy		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 immunodeficiency, X-linked immunodeficiency, Wiskott-Aldrich syndrome)		
Prevention of bacterial infection in patients with hypogammaglobulinemia and/or recurrent bacterial infections with B-		
cell chronic lymphocytic leukemia (CLL)		
Prevention of coronary artery aneurysms associated with Kawasaki syndrome		
☐ Motor neuropathy with multiple conduction block		
☐ 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 real and process opposity	<del> </del>	



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	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. 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 speci	fy below:	
Q5. Has the patient had an inadequate response or into	lerance to statins?	
☐Yes	□No	
Q6. Does the patient have any of the following (please sometimes of the patient have any of the following (please sometimes). It is a pregnant to be pregnant to be pregnant or moderate CYP3A	ent abnormal liver functio	n tests
☐ None of the above		



Juxtapid-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



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 applicable	e):
*Please note that Envision will process the request as w	vritten, including drug name, w	ith 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 estions and sign.	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	s transmembrane conductance re	egulator (CFTR) gene that is
responsive to Kalydeco potentiation based on clinical and		general (or it is, general and it
Yes	□No	
Q6. For CONTINUING THERAPY, has the patient experie	enced improved or stable lung fur	nction while on Kalydeco
therapy?		
☐ Yes	□ No	



Kalydeco-1 Medicare

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

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



Kisqali-1 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if app	licable):
*Please note that Envision will process the request as v	vritten, including drug nan	ne, with no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
21 - 12 - 1010		
Directions / SIG:		
Please attach any pertinent medical history or information	n for this nationt that may sur	nnort annroval Please answer the
	estions and sign.	sport approval. I loaded allower the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	/
Q2. If the request is for CONTINUING THERAPY, plea	se provide the start date (M	M/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 perimenopau	usal female	
☐ The patient's disease is hormone receptor (HR)		
☐ The patient's disease is human epidermal growth factor receptor 2 (HER2)-negative		
The medication will be used in combination with an aromatase inhibitor for initial endocrine-based treatment		
☐ The medication will be used in combination with	fulvestrant as initial endocr	ine 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, please provide the start date (MM/YY):		
Q3. Please indicate the patient's diagnosis for the reques	sted medication: *	
☐ Hyperglycemia (in a patient with endogenous		
Cushing's syndrome who has failed surgery or who is	☐ Other	
ineligible for surgery)		
Q4. If the patient's diagnosis is OTHER, please specif	y below:	
	•	
Q5. Is the patient pregnant?		
☐ Yes		
□ No		
☐ Patient is not female		



Korlym-1 Medicare

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

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



Kuvan-2 Medicare

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

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



Kuvan-2 Medicare

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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process.

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



Kynamro-1 Medicare

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

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



Fax back to: 877-503-7231

**EOC ID:** 

Phone: 800-361-4542

Kynamro-1 Medicare

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process.

Patient Name:	Prescriber Name:
Prescriber Signature	Date



Lenvima-1 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if a	applicable):
*Please note that Envision will process the request as w	ritten, including drug n	ame, with no substitution.
	☐ Expedited/Urgen	t
Drug Name and Strength:		
Directions / SIG:		
Diagram of the control of the contro	- f 4 -  4  4   4	Discount of the second of the
Please attach any pertinent medical history or information following qu	i for this patient that may sestions and sign.	support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing thera	ару
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	tastatic, progressive)	
☐ Other		
Q4. For RENAL CELL CARCINOMA, will the requested	d medication be used in co	ombination with everolimus
(Afinitor)?		
☐ Yes	☐ No	
Q5. For RENAL CELL CARCINOMA, has the patient re	eceived at least one (1) pr	ior anti-angiogenic therapy?
Yes	☐ No	
Q6. For THYROID CANCER, is the patient's disease re	efractory to radioactive iod	line?
☐ 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

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



Letairis-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	fapplicable):
*Please note that Envision will process t	he request as written, including drug	name, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions / SIC:		
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 this request for initial or continuing	therapy?	
☐ Initial therapy	☐ Continuing the	гару
Q2. For CONTINUING THERAPY, ple	ase specify the start date (MM/YY):	
Q3. Please indicate the patient's diagnos	is for the requested medication:	
☐ Pulmonary arterial hypertension (PAH), WHO Group I ☐ Other		
Q4. If the patient's diagnosis is OTHER	R, please specify below:	
Q5. For PAH, has the diagnosis been con unable to undergo a right heart catheterize	· ·	Doppler echocardiogram if patient is
Yes	□ No	
Q6. Is the patient pregnant?		
☐Yes	□No	
Q7. For FEMALE PATIENTS OF CHILD-	BEARING POTENTIAL, please select al	I that apply:
☐ Pregnancy has been excluded price	·	
☐ The patient has been educated ab	out the potential hazards associated with rill be using an IUD or two appropriate co	
	in 50 daing an 10D of two appropriate co	The description of the state of



Letairis-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:	
<ul><li>☐ None of the above</li><li>☐ N/A - The patient is not a female of child-bearing potential</li></ul>		
Q8. Is the medication prescribed by or in consultation with a pulmonologist or cardiologist?		
☐Yes	□ No	
Prescriber Signature	Date	



Leukine-1 Medicare

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

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



Leukine-1 Medicare

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

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



Leukine-1 Medicare

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

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



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 intolerance or contraindication to) at least one of the following medications which are labeled for the treatment of diabetic neuropathy (please check all that apply)?  Cymbalta  Lyrica  Other  None of the above			



Lidocaine Patch-1 Medicare

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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process.

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



Lorbrena-3 Medicare

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

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	written, including drug i	name, with no substitution.
	☐ Expedited/Urge	nt
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informatio	n for this patient that may uestions and sign.	support approval. Please answer the
ionowing qu	uestions and sign.	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	гару
CO For CONTINUING THEDADY places provide the	start data (MANA)	
Q2. For CONTINUING THERAPY, please provide the	start date (MIN/YY):	
Q3. Please indicate the patient's diagnosis for the reques	eted medication:	
☐ Non-small cell lung cancer (NSCLC), metastatic	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specifi	y below:	
Q5. Is the patient anaplastic lymphoma kinase (ALK)-pos	zitive?	
Yes	☐ No	
Q6. Has the patient experienced disease progression on	any of the following (plea	ase select all that apply)?
☐ Alectinib (Alecensa)		
☐ Ceritinib (Zykadia)		
☐ Crizotinib (Xalkori) AND at least 1 other ALK inhibi	tor for metastatic disease	
☐ None of the above		
O7 Will the nations be taking this modication in combined	tion with a atrana CVD2A	inducer which has notestial for
Q7. Will the patient be taking this medication in combinat hepatotoxicity?	uon wiin a sirong CYP3A	moder, which has potential for
incpatotoxicity:		



Lorbrena-3 Medicare

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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process.

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



Lupron-2 Medicare

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

Patient Name:	Prescriber Name:		
	Fax:	Phone:	
Date of Birth:	Office Contact:	i none.	
Group Number:	NPI:	State Lic ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Primary Phone:	Specialty/facility name (	if applicable):	
*Please note that Envision will process the request a	s written, including drug	name, with no substitution.	
☐ Expedited/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) ☐ Other	in children
Q6. For ANEMIA DUE TO UTERINE LEIOMYOMATA	(FIBROIDS), please select all that apply:
☐ Patient is preoperative	☐ None of the above
Q7. If the patient's diagnosis is OTHER, please specify	below.
Q8. For FEMALE PATIENTS, select all that apply:	
☐ Patient is pregnant	
☐ Patient is breastfeeding	
☐ Patient has undiagnosed abnormal vaginal bleedin☐ None of the above	9
Q9. Will the patient be utilizing non-hormonal contracepti	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 has deleterious or suspected delete	• •	, -	
☐ 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 select all that apply to this patient:		
☐ The patient has deleterious or suspected delete cancer	erious germline BRCA-mutated (gBRCAm) advanced ovarian	
<ul><li>☐ The patient has been treated with three (3) or more prior lines of chemotherapy</li><li>☐ None of the above</li></ul>		
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



Mektovi-3 Medicare

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

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



Prescriber Signature

**EOC ID:** 

Mektovi-3 Medicare

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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process. **Patient Name: Prescriber Name:** ☐ Yes ☐ No

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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 as	written, including drug	g name, with no substitution.
	☐ Expedited/Urg	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informati following or	ion for this patient that ma questions 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. For CONTINUING THERAPY, please provide the	e start date (MM/YY):	
Q3. For CONTINUING THERAPY, has the patient ex	perienced an objective re	esponse to therapy (such as no or
slowed progression of disease)?		
Yes	□No	
Q4. Please indicate which medication this request is for	Ϊ.	
Aubagio		
Avonex		
Betaseron		
Gilenya		
Glatiramer		
Plegridy		
☐ Tecfidera		
Q5. For AUBAGIO, please select all that apply to this	s patient:	
☐ Patient has severe hepatic impairment		
☐ Patient is currently being treated with leflunon	nide	
☐ 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 Name.  Prescriber Name.  Prescriber Name.  Prescriber Name.		
Q6. For GILENYA, please select all that apply to this patient:  Recent (within the last 6 months) occurrence of: myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, or Class III/IV heart failure  History or presence of Mobitz Type II 2nd degree or 3rd degree AV block or sick sinus syndrome, unless patient has a pacemaker  Baseline QTc interval greater than or equal to 500 ms  Receiving concurrent treatment with Class Ia or Class III anti-arrhythmic drugs (such as quinidine, procainamide, amiodarone, or sotalol)  None of the above		
Q7. For GILENYA, will the patient be observed for sign least 6 hours after the first dose?	s and symptoms of bradycardia in a controlled setting for at	
_	<del>_</del>	
Q8. For GLATIRAMER, is the patient 18 years of age o		
☐ Yes	□ No	
Q9. Please indicate the patient's diagnosis for the request    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:	
	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:	
лети и при при при при при при при при при	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	written, including drug	name, with no substitution.
	☐ Expedited/Urge	ent
Orug Name and Strength:		
Directions / SIG:		
Directions / Sig.		
Please attach any pertinent medical history or informatio	n for this nationt that may	y sunnort annroyal Plaasa answer the
	uestions and sign.	support approval. Flease allswer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	Continuing the	гару
Q2. For CONTINUING THERAPY, please provide the	start date (MIM/11).	
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	n helom.	
Q4. If the patient's diagnosis is Officity, please specify	y below.	
0.5		
Q5. Will Nerlynx be used in a patient who has been previ	•	zumab-based therapy?
☐ Yes	☐ No	
Q6. Is the patient 18 years of age or older?		
☐ Yes	☐ No	
Q7. Is Nerlynx prescribed by (or in consultation with) and	oncologist?	
☐Yes	□No	



Nerlynx-3 Medicare

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

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



Neulasta-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	ipplicable):
*Please note that Envision will process the request as	written, including drug na	ame, with no substitution.
	☐ Expedited/Urgent	t
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informatio following qu	on for this patient that may s uestions and sign.	support approval. Please answer the
Q1. Is the request for initial or continuing therapy?		
	Continuing there	
☐ Initial therapy	Continuing thera	ару
Q2. For continuing therapy, please specify start date (	MM/YY):	
Q3. Please indicate the patient's diagnosis for the reques	sted medication below:	
☐ Prevention of chemotherapy-induced neutropenia (non-myeloid malignancies)	Other	
Q4. If the patient's diagnosis is OTHER, please specif	y below:	
Q5. For prevention of chemotherapy-induced febrile neutonal Patient experienced febrile neutropenia with a prio The patient is at high risk (greater than 20%) or int Patient is at low risk (less than 10%) but is at signineutropenia and the intent of chemotherapy is to prolong	or chemotherapy cycle termediate risk (10-20%) fo ficant risk for serious medi	or developing febrile neutropenia cal consequences due to febrile
Q6. Are the patient's complete blood count and platelet of	count being monitored at ba	aseline, and a regularly
thereafter?		
Yes	☐ No	



Neulasta-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. Please indicate if the patient has any of the following (select all that apply):		
☐ Treatment of febrile neutropenia		
☐ Known hypersensitivity to filgrastim		
☐ Use in the period 14 days before and 24 hours after administration of chemotherapy		
☐ Use in patients with myeloid malignancy		
☐ Use to increase the chemotherapy dose intensity or dose schedule beyond established regimens		
☐ None of the above		
Prescriber Signature	Date	



Ninlaro-4 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	
*Please note that Envision will process the request as written, including drug name, 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.	port approvant rouge anomer and
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:	
Multiple myeloma	Other	
Q4. If the patient's diagnosis is OTHER, please specify	below.	
Q5. Will the requested medication be used in combination	n with lenalidomide (Revlimid	and devamethasone?
·	,	, and dexametrideens.
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 witl	n a hematologist/oncologist?	
and the state of t		



Ninlaro-4 Medicare

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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process.

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



Northera-1 Medicare

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

Patient Name:	Dres sriber Name:	
	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	04-4- 1 :- ID.
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP: Primary Phone:	City, State ZIP:	١.
·	Specialty/facility name (if applicable	
*Please note that Envision will process the request as v	<u>_</u>	
Drug Name and Strength:	☐ Expedited/Urgent	
Directions / SIG:		
Please attach any pertinent medical history or information		pproval. Please answer the
following qu	estions and sign.	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. If the request is for CONTINUING THERAPY, plea	se provide the start date (MM/VV)	
Q2. If the request is for SCIVIIIVOIIVO II LIVE 1, pice	be provide the start date (MINI/11)	•
Q3. Please indicate the patient's diagnosis for the reques	ted medication:	
☐ Neurogenic orthostatic hypotension (NOH)	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify below:		
Q5. If the patient has a diagnosis of NOH, is the NOH due	e to any of the following (please se	elect all that apply)?
☐ Primary autonomic failure (Parkinson's disease, mu	ultiple system atrophy, or pure auto	onomic failure)
Dopamine beta-hydroxylase deficiency		,
☐ Non-diabetic autonomic neuropathy		
☐ None of the above		
Q6. If the patient has NOH that is NOT caused by any	of the issues listed in the provious	guestion, please specify the
cause of the patient's NOH:	of the issues listed in the previous	question, please specify the
cause of the patient effect.		
Q7. Does the patient have any of the following symptoms	(please select all that apply)?	
Orthostatic dizziness	(Figure 2010)	



Prescriber Signature

**EOC ID:** 

Northera-1 Medicare

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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process. **Patient Name: Prescriber Name:** Lightheadedness ☐ "Feeling that you are about to black out" ☐ None of the above

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Date



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:	ary 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 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, please provide the start date (MM/YY):			
Q2. If the request is for continuent of the training in pro-	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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process.

**Patient Name: Prescriber Name:** 

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Nuplazid-1 Medicare

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

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



Octreotide-1 Medicare

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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process.

Patient Name:	Prescriber Name:
Prescriber Signature	Date



Opsumit-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:	
rimary Phone: Specialty/facility name (if applicable):		
*Please note that Envision will process the request as w	vritten, including drug n	ame, with no substitution.
	☐ Expedited/Urger	nt
Drug Name and Strength:		
D'(*		
Directions / SIG:		
Please attach any pertinent medical history or information	n for this patient that may	support approval. Please answer the
	estions and sign.	оброт бри от по
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing there	ару
Q2. For CONTINUING THERAPY, please specify the start date (MM/YY):		
Q2.1 of CONTINUING THE U. 1, please speeny the s	tare date (MIVI/ 1 1).	
O2 Please indicate the national diagnosis for the request	tod modication:	
Q3. Please indicate the patient's diagnosis for the request		
☐ Pulmonary arterial hypertension (PAH) (World Healt Organization group I)	th ☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify	below:.	
Q5. Has diagnosis been confirmed by right heart catheter	ization?	
☐ Yes	□No	
Q6. If the patient is FEMALE, is she enrolled in the OPSU	IMIT REMS program?	
☐Yes		
□ No		
☐ Not applicable - patient is not female		
Q7. If the patient is FEMALE, has there been confirmation	that natient is currently l	NOT pregnant?
	i mai panem is currently i	TO Pregnant:
☐ Yes		



Opsumit-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:
□ No	
☐ Not applicable - patient is not female	
Q8. Will an IUD or two appropriate contraceptive methods	s be used for women of childbearing potential?
☐ Yes	
□ No	
☐ N/A - The patient is male or is not of child-bearing pot	tential
Q9. Is the medication prescribed by or in consultation with	h a pulmonologist or cardiologist?
☐Yes	□ No
Prescriber Signature	Date



Orilissa-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:	
rimary 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
Orug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informati following o	on for this patient that ma questions and sign.	y support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	erapy
Q2. For CONTINUING THERAPY, please indicate the	e start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the reque	ested medication:	
☐ Endometriosis (with moderate to severe pain)	☐ Other	
Q4. If the patient's diagnosis is OTHER, please speci	fy below:	
Q5. Is the patient 18 years of age or older?		
☐ Yes	☐ No	
Q6. Does the patient have any of the following (please s	select all that apply)?	
☐ Pregnancy		
☐ Known osteoporosis		
☐ Severe hepatic impairment		
☐ Current use of strong organic anion transporting p	polypeptide (OATP) 1B1	inhibitors
☐ None of the above		



Orilissa-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	



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 ap	plicable):
Please note that Envision will process the request as v	vritten, including drug nai	me, with no substitution.
	☐ Expedited/Urgent	
Orug 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.	ipport approval. Please answer 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. For CONTINUING THERAPY, is the patient tolerar following (please select all that apply)?  Improved FEV1 Weight gain Decreased exacerbations Other None of the above	ting and responding to the r	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 confirm	med 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

Member/Subscriber Number: Pate of Birth: Group Number:	Fax: Office Contact:	Phone:
Group Number:	NDI.	
•	NPI:	State Lic ID:
ddress:	Address:	
city, State ZIP:	City, State ZIP:	
rimary Phone:	Specialty/facility name (if	f applicable):
Please note that Envision will process the request a	as written, including drug	name, with no substitution.
	☐ Expedited/Urge	ent
rug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following	ation for this patient that may g questions and sign.	y support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	егару
Q2. For CONTINUING THERAPY, please provide	the start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the req	juested medication:	
Dyspareunia (moderate to severe)		
☐ Atrophic vaginitis		
☐ Moderate to severe vaginal dryness due to meno	pause	
☐ Other		
Q4. If the patient's diagnosis is OTHER, please spe	ecify below:	
Q5. Is the patient's condition caused by menopause?		
☐ Yes	□No	
Q6. Is the patient 18 years of age or older?		
	□ N-	
☐ Yes	□ No	
Q7. Does the patient have any of the following (please	e select all that apply)?	
☐ Acute thromboembolism or a past history of thr		iding patients with a history of DVT,



Osphena-1 Medicare

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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process.

Prescriber Name:	
r myocardial infarction)	
sia	
g of an undetermined origin	
S	myocardial infarction) ia



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	W:	
Q5. Does the patient have any of the following exclusi	one? (Please select all the	at apply):
<ul><li>☐ Known or suspected carcinoma of the prostate</li><li>☐ Carcinoma of the breast in a female patient with</li></ul>	,	5)
Nephrosis (the nephrotic phase of nephritis)	Ппурегсавсенна	
Hypercalcemia		
☐ Pregnancy		
☐ None of the above		



Oxandrolone-1 Medicare

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

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



Oxervate-1 Medicare

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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process.

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



PCSK9 Inhibitors-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	e request as written, including drug r	name, with no substitution.
	☐ Expedited/Urger	nt
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical histor	y 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	herapy?	
☐ Initial therapy	☐ Continuing ther	apv
Q2. For CONTINUING THERAPY, pleas	se specify the start date (MM/YY):	
Q3. Please indicate which medication this	request is for:	
│ │	☐ Repatha	
_		
Q4. Please indicate the patient's diagnosis	for the requested medication:	
☐ Heterozygous familial hypercholesterol	lemia (HeFH)	
Homozygous familial hypercholesterole		
Clinical atherosclerotic cardiovascular		
Established CVD (to reduce the risk of	MI, stroke, coronary revascularization)	
☐ Other		
Q5. For HeFH, has the diagnosis been of	confirmed by either of the following?	
Genotyping	, s	
Simon Broome criteria		
☐ None of the above		
☐ Notife of title above		
Q6. For HeFH, if the diagnosis was conf	irmed by Simon Broome criteria, please	select all that apply to this patient:
☐ Total cholesterol greater than 29	0 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			
Q 13. II Statins are contraindicated or not tolerated by tr	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:	] ;	Specialty/facility nan	ne (if applicable):
*Please note that Envision will pro	cess the request as wri	itten, including dı	rug name, with no substitution.
		☐ Expedited/	Urgent
Drug Name and Strength:			
Directions / SIG:			
Please attach any pertinent medic		for this patient that stions and sign.	may support approval. Please answer the
Q1. Is this request for initial or con-	tinuing therapy?		
☐ Initial therapy	therapy   Continuing therapy		
Q2. For continuing therapy, plea	ase specify start date (MN	И/YY):	
Q3. Please indicate the patient's di	iagnosis for the requester	d medication: *	
☐ Chronic Hepatitis B	☐ Chronic Hepa	atitis C	Other
Q4. For CHRONIC HEPATITIS	C, please indicate the pa	tient's genotype be	elow:
Q5. For CHRONIC HEPATITIS		nt naive or experier	nced?
☐ Treatment naive (i.e. no p Hepatitis C)	previous treatment for	☐ Treatmer for Hepatitis C	nt experienced (i.e. has received treatment in the past)
Q6. For CHRONIC HEPATIT regimens as well as the resp	•	•	d, please list all previous treatment lapser, etc):
Q7. For CHRONIC HEPATITIS	C, will Pegasys be used i	in conjunction with	Sovaldi?
☐ Yes		□No	
Q8. If the patient's diagnosis is	OTHER, please specify b	elow:	



Pegasys-2 Medicare

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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process.

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



Pomalyst-1 Medicare

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

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



Pomalyst-1 Medicare

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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process.

Defined Name	Para author Name	
Patient Name:	Prescriber Name:	
Q6. For FEMALES OF CHILD-BEARING POTENTIAL, please select all that apply:		
<ul> <li>☐ Two (2) negative pregnancy tests have been obtain</li> <li>☐ Patient will receive pregnancy test monthly during</li> <li>☐ Patient is male or not of reproductive potential</li> <li>☐ None of the above</li> </ul>	• • • • • • • • • • • • • • • • • • • •	
Q7. Please indicate the prescriber's specialty below:		
☐ Oncologist ☐ Hematolog	gist Other	
Q8. If the answer is OTHER, please specify:		
Prescriber Signature	 Date	



Promacta-3 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable	<del>;</del> ):
*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 informatio	n for this patient that may support	approval. Please answer the
	uestions and sign.	
O1 to required for initial or continuing the game?		
Q1. Is request for initial or continuing therapy?	_	
Initial therapy	Continuing therapy	
Q2. For continuing therapy, please specify start date (MM/YY):		
3	,	
Q3. Please indicate the diagnosis for which the requested	d medication is being prescribed:	
Idiopathic thrombocytopenic purpura (ITP)	a meanagem to being precented.	
Hepatitis C infection associated thrombocytopenia		
	to immunosuppressive therapy or	in combination with
Severe aplastic anemia with insufficient response to immunosuppressive therapy or in combination with immunosuppressive therapy		
☐ Other		
O4 If the nationt's diagnosis is OTHED places specifi	, holow:	
Q4. If the patient's diagnosis is OTHER, please specify	y below.	
Q5. Has the patient had an insufficient response or intole	rance to corticosteroids, immunog	lobulins, or splenectomy?
☐ Yes	☐ No	
Q6. Is the platelet (Plt) count at time of diagnosis: less the	an 30,000/mcL OR less than or ed	ual to 50,000/mcL with
significant mucous membrane bleeding or risk factors for		,
☐ Yes	□ No	
	□ · · ·	



Promacta-3 Medicare

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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process.

Patient Name:	Prescriber Name:	
Q7. Will liver function be assessed pretreatment and regularly throughout therapy?		
Yes	□ No	
Q8. Are alanine aminotransferase levels greater than or effollowing characteristics: progressive, persistent, accompevidence of hepatic decompensation?	equal to 3 times the upper limit of normal with any of the anied by increased bilirubin or symptoms of liver injury or	
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	
• • • • • • • • • • • • • • • • • • • •	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	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	nt
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 of the state	following questions and sign.	support approval. Please answer the
	following questions and sign.	
Q1. Is this request for initial or continuing the	following questions and sign. erapy?	
Q1. Is this request for initial or continuing the	following questions and sign. erapy?	
Q1. Is this request for initial or continuing the Initial therapy  Q2. For CONTINUING THERAPY, please	erapy?  Continuing the 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	erapy?  Continuing the indicate the start date (MM/YY):	
Q1. Is this request for initial or continuing the Initial therapy  Q2. For CONTINUING THERAPY, please	erapy?  Continuing the 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	erapy?  Continuing the indicate the start date (MM/YY):  or the requested medication below:	
Q1. Is this request for initial or continuing the linitial therapy  Q2. For CONTINUING THERAPY, please  Q3. Please indicate the patient's diagnosis for line line line line line line line line	erapy?  Continuing the indicate the start date (MM/YY):  or the requested medication below:	
Q1. Is this request for initial or continuing the linitial therapy  Q2. For CONTINUING THERAPY, please  Q3. Please indicate the patient's diagnosis for line line line line line line line line	erapy?  Continuing the indicate the start date (MM/YY):  or 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 Nan	ne:	
	·		
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 as written, including drug name, with no substitution.			
	☐ Expedited/Urg	ent	
Drug Name and Strength:			
Directions / SIG:			
Please attach any pertinent medical history or informa following	ition 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 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 the	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 cytogenetiabnormalities?			



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 (i	f applicable):
*Please note that Envision will process the request as v	vritten, including drug	name, with no substitution.
	☐ Expedited/Urg	ent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that ma lestions 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 la	boratory test



Rubraca-1 Medicare

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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process.

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



Rydapt-1 Medicare

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

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



Rydapt-1 Medicare

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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process.

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



Samsca-2 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if	fapplicable):
*Please note that Envision will process the r	request as written, including drug	name, with no substitution.
	☐ Expedited/Urge	ent
Drug Name and Strength:		
Directions / SIG:		
Directions / Sig.		
Please attach any pertinent medical history of	or information for this patient that may	support approval. Please answer the
	following questions and sign.	
Q1. Is the request for initial or continuing ther	rany?	
	_	rany
☐ Initial therapy	Continuing the	чару
Q2. For continuing therapy, please specify	start date (MM/YY):	
Q3. Please indicate the patient's diagnosis fo	r the requested medication:	
☐ Hypervolemic hyponatremia		
☐ Euvolemic hyponatremia		
☐ Other		
Q4. If the patient's diagnosis is OTHER, pl	ease specify below:	
Q II II alio pationico diagnosio io o II I El II, pi	oute openly below.	
Q5. Does the patient have anuria?		
· ·	□No	
Yes	□ No	
Q6. Does the patient require an URGENT inc	crease in serum 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-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	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 lestions and sign.	support approval. Please answer the
Tollowing qu		
Q1. Is this request for initial or continuing therapy?		
	Continuing the	rany
☐ Initial therapy	Continuing the	нару
Q2. For continuing therapy, please specify start date (N	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. Has PAH been confirmed by right heart catheterization	on or by Doppler echoca	rdiogram if patient is unable to
undergo a right heart catheterization (e.g., patient is frail,	• • •	and grain in parison to an abrid to
☐ Yes	□No	
Q6. Is the patient currently on nitrate therapy?		
☐ Yes	□No	
Q7. Is the medication prescribed by or in consultation with	h a pulmonologist or car	diologist?
☐ Yes	☐ No	
I .		



Sildenafil-3 Medicare

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

	ent. Certain requests for coverage require review with the prescribing physician he number listed above. Please note any information left blank or illegible m	
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	шегару
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, local	ly advanced or meta	static carcinoid gastroenteropancreatic
neuroendocrine tumor		
Hyperthyroidism secondary to thyrotropinoma		
☐ Carcinoid syndrome		
Other		
Q4. If diagnosis is ACROMEGALY, please check all the	at apply:	
☐ Patient has had an inadequate response to sur	gery and/or radiother	ару
☐ 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 exp	erienced 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 (if applicable	e):
*Please note that Envision will process the request as v	vritten, including drug name, wi	ith no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Diagon office and marking out modified biotomy or information	a fau thia maticut that was a summant	onneced Diagon angues the
Please attach any pertinent medical history or information following qu	estions and sign.	approvai. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. For continuing therapy, please specify start date (N	MM/YY).	
Q3. Please indicate the patient's diagnosis for the reques	ted medication: *	
☐ Chronic myeloid leukemia (CML) in chronic phase, Ph	niladelphia chromosome-positive (	(Ph+) [newly diagnosed]
☐ Chronic myeloid leukemia (CML) in chronic, accelerate	·	, ,
chromosome-positive (Ph+)		
Acute lymphoblastic leukemia (ALL), Philadelphia chr	omosome-positive (Ph+)	
☐ Newly diagnosed Ph+ Acute lymphoblastic leukemia (ALL) in combination with chemotherapy		
☐ Other		
Q4. If the patient's diagnosis is OTHER, please specify	below:	
ann an panama anginara a anna , prana apan,		
OF the nations had registered as intelegrance to prior	thoronyO	
Q5. Has the patient had resistance or intolerance to prior		
Yes	□ No	
Q6. If yes, did the prior therapy include imatinib (Gleev	ec)?	
☐ Yes	□ No	
	□ 140	



Sprycel-1 Medicare

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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process.

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



Stivarga-5 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	00.00.00
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
mary 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
OO For continuing the name alone and if	A DATE OF THE STATE OF THE STAT	
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 metastatic)		
☐ Hepatocellular carcinoma (previously treated with sorafenib [Nexavar])		
☐ Other		
Q4. For COLORECTAL CANCER, is the	patient's disease KRAS mutation nega	ative?
Yes	□ No	
Q5. For COLORECTAL CANCER, please select all that apply):	indicate which of the following the pa	tient has previously tried (please
☐ Fluoropyrimidine-, oxaliplatin, and ☐ Bevacizumab (Avastin)	irinotecan-based chemotherapy	
☐ Panitumumab (Vectibix)		
Cetuximab (Erbitux)		
Other		



Stivarga-5 Medicare

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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process.

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



Sutent-4 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if 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	n for this nationt that may sunno	rt annroval Please answer the
	estions and sign.	it approval. I lease allower the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing therapy	
Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):		
,		,
Q3. Please indicate the patient's diagnosis below: *		
☐ Progressive, well-differentiated pancreatic neuroendocrine tumors in a patient with 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, has	s the patient had disease progre	ession on or intolerance to
Gleevec (imatinib)?	a the patient had alleged progre	
Yes	□No	
Q6. Is the patient 18 years of age or older?		
☐ Yes	□ No	
I .		



Sutent-4 Medicare

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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process.

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



Sylatron-2 Medicare

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

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



Sylatron-2 Medicare

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

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



Symdeko-3 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	FIIOHE.
Group Number:	NPI:	State Lic ID:
Address:	Address:	State Ele IB.
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	
*Please note that Envision will process the request as written, including drug name, with no substitution.		
□ Expedited/Urgent		
Drug Name and Strength:	,	
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	27
ппиагинетару		ργ
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:	
☐ Cystic fibrosis	☐ Other	
Q4. If the patient's diagnosis is OTHER, please specify	y below:	
Q5. Please select if any of the following apply to this patie	ent:	
☐ The patient is homozygous for the F508del mutation	on	
☐ The patient has a mutation in the cystic fibrosis tra	nsmembrane conductance	regulator (CFTR) gene that is
responsive to tezacaftor/ivacaftor verified by a FDA-appr	roved CF mutation test	
☐ None of the above		
Q6. Is the patient 12 years of age or older?		
☐Yes	□No	



Symdeko-3 Medicare

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

Patient Name:	Prescriber Name:
	·



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:	
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/Urge	ent
Drug Name and Strength:		
Directions / SIG:		
Diagon attack any montinent modical biotom, on informati	for this motion t that may	vision and amountain Disease amountains
Please attach any pertinent medical history or information following q	on for this patient that may uestions and sign.	y support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing the	erapy
.,		
Q2. For INITIAL THERAPY, does the patient have ina	idequate glycemic contro	I (HbA1c greater than 7% but less than
9%)?	_	
Yes	☐ No	
Q3. For CONTINUING THERAPY, please indicate the	e start date (MM/YY):	
, ,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	(	
Q4. For CONTINUING THERAPY, has the patient taken	Symlin in the previous 6	months and demonstrated a
reduction in HbA1c since initiating Symlin therapy?		
Yes	☐ No	
Q5. Please indicate the patient's diagnosis for the reque	sted medication:	
☐ Diabetes mellitus (type 1 or type 2), adjunctive		
treatment	☐ Other	
Q6. If the patient's diagnosis is OTHER, please specif	fy holow:	
Q0. If the patient's diagnosis is OTTIEN, please specific	ly 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)?
<ul> <li>☐ Gastroparesis</li> <li>☐ Hypoglycemia unawareness (i.e. inability to detect</li> <li>☐ Severe hypoglycemia that required assistance duri</li> <li>☐ The patient requires drug therapy to stimulate gast</li> <li>☐ None of the above</li> </ul>	-
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 request as written, including drug name, with no substitution.		
☐ Expedited/Urgent		
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.		
Q1. Is this request for initial or continuing 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 with trametinib		
☐ Anaplastic thyroid carcinoma, Locally advanced or metastatic, with BRAF V600E mutation, in combination with trametinib ☐ Other		
Outer		
Q4. If the patient's diagnosis is OTHER, plea	ase specify below:	
Q5. Does the patient have a positive BRAF V6	00E or V600K mutation as detecte	d by an FDA-approved test?
☐ Yes	□ No	
Q6. Does the patient have wild-type BRAF mel	anoma?	
☐ Yes	☐ No	



Prescriber Signature

**EOC ID:** 

Tafinlar-6 Medicare

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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process. **Patient Name: Prescriber Name:** Q7. Is the requested medication being prescribed by an oncologist? ☐ Yes

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Date



Tagrisso-4 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	i none.
Group Number:	NPI:	State Lic ID:
Address:	Address:	3.2.0 2.0 .2.
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 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, ple	ease provide the start da	te (MM/YY):
Q3. Please indicate the patient's diagnosis for the reque	ested medication:	
☐ Non-small cell lung cancer (NSCLC), metastatic ☐ Other		
Q4. If the patient's diagnosis is OTHER, please speci	fy below:	
Q5. Was the patient's diagnosis confirmed by an FDA-a	pproved test?	
☐ Yes	□No	
Q6. Please select if any of the following apply to this pat	tient:	
☐ The disease is metastatic EGFR mutation-positive		
☐ There is confirmed presence of T790M EGFR tun		
☐ The patient's disease has progressed on or after		hibitor based therapy
☐ None of the above	•	.,



Prescriber Signature

Fax back to: 877-503-7231

Date

**EOC ID:** 

Phone: 800-361-4542

Tagrisso-4 Medicare

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



Takhzyro-1 Medicare

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

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



Takhzyro-1 Medicare

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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process.

Patient Name:	Prescriber Name:
Prescriber Signature	Date



Talzenna-3 Medicare

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

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



Prescriber Signature

**EOC ID:** 

Talzenna-3 Medicare

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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process. **Patient Name: Prescriber Name:** ☐ Yes ☐ No

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Date



Tasigna-5 Medicare

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

Patient Name:	Prescriber Name:	
-		
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	0.1.1.10
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	- P. alda
Primary Phone:	Specialty/facility name (if ap	oplicable):
*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 informatio	n for this patient that may solestions and sign.	upport approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing thera	ру
Q2. If the request is for CONTINUING THERAPY, plea	ase provide the start date (N	MM/YY):
Q3. Please indicate the patient's diagnosis for the reques	ted medication: *	
☐ Philadelphia chromosome positive chronic myeloid le		nic phase (newly diagnosed)
Chronic phase (CP) and accelerated phase (AP) Ph+	, ,	ile priase (flewly diagnosed)
Other	OWL	
Q4. Is the patient resistant to or intolerant to prior there	apy?	
☐ Yes	☐ No	
Q5. If the patient's diagnosis is OTHER, please specify	, helow.	
go. If the patients diagnosis is official, piedse specify	, 50,011.	
Q6. Is the requested medication being prescribed by an o	oncologist?	
☐ Yes	☐ No	



Tasigna-5 Medicare

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

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



Tegsedi-4 Medicare

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

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (	if applicable):
*Please note that Envision will process the request as v	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	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 specify the	start date (MM/YY):	
Q3. Please indicate the patient's diagnosis for the reques	sted medication:	
Polyneuropathy of hereditary transthyretin-mediated amyloidosis	d Other	
Q4. If the patient's diagnosis is OTHER, please specify	y below:	
Q5. Is the patient 18 years of age or older?		
☐ Yes	□No	
Q6. Is the patient enrolled in the Tegsedi REMS program	?	
☐ Yes	□No	
Q7. Do any of the following apply to the patient (please c	heck all that apply)?	
☐ Platelet count is below 100 x 10(9)/L		
☐ Documented history of acute glomerulonephritis ca☐ None of the above	aused by inotersen	



Prescriber Signature

**EOC ID:** 

Tegsedi-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



Testosterone-1 Medicare

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

Patient Name:	Prescriber Name:		
	Fax:	Phone:	
Date of Birth:	Office Contact:	ee.	
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 / Sig.			
Please attach any pertinent medical history or information		y support approval. Please answer the	
following qu	uestions and sign.		
Q1. Is this request for initial or continuing therapy?			
☐ Initial therapy	☐ Continuing the	erapy	
Q2. For CONTINUING THERAPY, please indicate Sta	art Date (MM/YY):		
, ,	,		
Q3. Please indicate the patient's diagnosis below:			
☐ Hypogonadism			
☐ Deficiency or absence of endogenous testosterone			
☐ Other			
Q4. If the patient's diagnosis is OTHER, please specify below:			
Q5. Do any of the following apply to this patient (please s	select all that apply)?		
☐ Patient is female	11 27		
☐ Patient has prostate cancer			
Patient has breast cancer			
☐ None of the above			
Q6. Please indicate the patient's testosterone level PRIC	DR to start of therapy:		
☐ Total testosterone GREATER than 300 ng/dL, free or bioavailable testosterone GREATER than 5 ng/dL			
☐ Total testosterone LESS than 300 ng/dL, free or bioa		_	
		Ŭ	



Prescriber Signature

**EOC ID:** 

Testosterone-1 Medicare

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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process. **Patient Name: Prescriber Name:** Absence of endogenous testosterone ■ None of the above

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Date



Tetrabenazine-2 Medicare

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

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



Tetrabenazine-2 Medicare

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

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



Thalomid-2 Medicare

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

Patient Name:	Prescriber Name:	
	Fax:	Phone:
Date of Birth:	Office Contact:	e.ie.
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (	(if applicable):
*Please note that Envision will process the request a	ns written, including drug	name, with no substitution.
	☐ Expedited/Urg	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informa following	ntion for this patient that ma g questions and sign.	ay support approval. Please answer the
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing 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 in Thalomid be used as monotherapy?	nodosum leprosum and als	so has moderate to severe neuritis, will



Thalomid-2 Medicare

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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process.

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



Tibsovo-4 Medicare

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

Deficint Name:	Dung awihan Mamar	
Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applica	ıble):
*Please note that Envision will process the request as w	ritten, including drug name,	with no substitution.
	☐ Expedited/Urgent	
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information	n for this patient that may suppo estions and sign.	rt approval. Please answer the
Tollowing qu	estions and sign.	
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:	
Acute myeloid leukemia (AML), relapsed or refractor	ry	
Q4. If the patient's diagnosis is OTHER, please specify	below:	
Q5. Does the patient have a susceptible isocitrate dehydromatical dehydromatical control of the	ogenase-1 (IDH1) mutation?	
	, ,	
☐ Yes	□ No	
Q6. Is the requested medication prescribed by (or in cons	ultation with) an oncologist or h	nematologist?
☐ 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

Tibsovo-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:	
Prescriber Signature	Date	



Tracleer-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 reque	st as written, including drug	g name, with no substitution.
	☐ Expedited/Urg	gent
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or info	rmation for this patient that ma	av support approval. Please answer the
	ving questions and sign.	., cappers approximations and another mic
Q1. Is this request for initial or continuing therapy?		
	<u></u>	
☐ Initial therapy	☐ Continuing th	nerapy
Q2. If the request is for CONTINUING THERAP	Y, please provide the start da	te (MM/YY):
·		•
Q3. Please indicate the patient's diagnosis for the	requested medication:	
☐ Pulmonary arterial hypertension (PAH)	□ Other	
T diffordity different hypertension (1741)		
Q4. If the patient's diagnosis is OTHER, please	specify below:	
Q5. Has the diagnosis of PAH been confirmed by	either of the following?	
☐ Right heart catheterization	on the following :	
Doppler echocardiogram (if patient is unable	to undergo a right heart cath	eterization)
☐ None of the above	to andergo a right heart oath	Cionzation
Q6. Does the patient have World Health Organizat	ion (WHO) Group 1 and New	York Heart Association (NYHA)
Functional Class II-IV symptoms?		
☐ Yes	☐ No	
Q7. FOR FEMALE PATIENTS OF CHILD-BEARIN	IG POTENTIAL has pregnan	cy been excluded prior to therapy and
patient will use two forms of reliable contraception		by 20011 oxological prior to thorapy and



Tracleer-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 ☐ 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 cyclosporing	e A or glyburide therapy?
☐Yes	□ No
Q10. Is the medication prescribed by or in consultation w	ith a pulmonologist or cardiologist?
☐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:	Specialty/facility name (if	applicable):
*Please note that Envision will process the request as	written, including drug r	name, with no substitution.
	☐ Expedited/Urger	nt
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or informati	on for this nationt that may	support approval. 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, ple	asse provide the start date	(NANA/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 speci	fv below:	
and the parameter and greeners to a recommendation of the	., 20.0	
OF lather affect a section of a section of the sect	of an fire atoms O	
Q5. Is the patient a post-menopausal female at high risk		
Yes	☐ No	
Q6. Is the patient at least 18 years of age or older?		
☐ Yes	□No	
Q7. Has the patient experienced a prior fragility fracture	?	
☐ Yes	□No	
_		
Q8. Does the patient have any of the following risk factor	ors for fracture (please sele	ect all that apply)?
☐ Advanced age	☐ Rheumatoid a	rthritis



Tymlos-4 Medicare

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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process.

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



Uptravi-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
Orug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information		support approval. Please answer the
following qu	estions and sign.	
Q1. Is this request for initial or continuing therapy?		
☐ Initial therapy	☐ Continuing ther	гару
Q2. If the request is for CONTINUING THERAPY, please	se provide the start date	(MM/YY):
Q3. Please indicate the patient's diagnosis for the request	ted medication:	
☐ Pulmonary arterial hypertension (PAH) (WHO Group	o I)	
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	to at least one other PA	.H agent (e.g. sildenafil)?
☐ Yes	☐ No	
Q7. Is the patient 18 years of age or older?		
☐ Yes	☐ No	
Q8. Is the medication prescribed by or in consultation with	n a pulmonologist or card	liologist?



Uptravi-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	re 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:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if a	applicable):
*Please note that Envision will process th	e request as written, including drug n	ame, 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	support approval. Please answer the
riodes attach any permitting medical meter	following questions and sign.	support approvant rouge anoner and
Od to this was word for initial on a setimation of	h a range 2	
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	s for the requested medication: *	
Acute myeloid leukemia (AML), newly	·	
	mall lymphocytic lymphoma (SLL) (with c	or without 17n deletion)
Other	man lymphocytic lymphoma (CLL) (with C	without 17 p deletion)
Q4. For NEWLY DIAGNOSED AML, ple	,	
The patient is 75 years of age or older		
The patient cannot use intensive induction chemotherapy		
☐ Venclexta will be used in combination with azacitadine, decitabine, or low-dose cytarabine		
☐ None of the above		
Q5. For CLL/SLL, has the patient receiv	ved at least one (1) prior therapy?	
☐Yes	☐ No	
Q6. If the patient's diagnosis is OTHER	please specify below:	
Zo a.o pado o diagnosio io offici	, p. 1223 apost., 20.011.	



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:	Prescrib	per 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 sife helps		
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 as monotherapy ☐ Verzenio will be used in combination with fulvestrant (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		. Islando di Tadquii



Verzenio-1 Medicare

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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process.

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



Vitrakvi-1 Medicare

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

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



Vitrakvi-1 Medicare

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

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



Vizimpro-3 Medicare

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

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



Vizimpro-3 Medicare

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

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



Xalkori-1 Medicare

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

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



Xalkori-1 Medicare

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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process.

Patient Name:	Prescriber Na	me:
	·	
Prescriber Signature		 Date



Xeljanz-5 Medicare

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

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



Xgeva-2 Medicare

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

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



Xolair-3 Medicare

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

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



Xolair-3 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:
has a contraindication to ICS or LABA  None of the above	
Q7. If the patient's diagnosis is OTHER, please specify	below:
Q8. Please indicate the patient's age below:	
☐ Under 6 years	6 years or older
Q9. Please indicate the prescriber's specialty below:  Allergist Immunologist Pulmonologist Dermatologist Other  Q10. If the prescriber's specialty is OTHER, please specialty	ecify:
Prescriber Signature	Date



Xospata-1 Medicare

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

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



Xospata-1 Medicare

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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process.

Patient Name:	Prescriber Name:
Prescriber Signature	Date



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
Q2. If the request is for CONTII	NUING THERAPY, please provide the s	start date (MM/YY):
Q3. Please indicate the patient's of	diagnosis for the requested medication b	pelow:
☐ Prostate Cancer (metastatic, o	castration-resistant)	
☐ Prostate Cancer (non-metasta	atic, castration-resistant)	
Q4. FOR Metastatic prostate ca	ancer: Has the patient tried and failed Zy	ytiga?
☐ Yes	□No	
Q5. If the patient has not trich history of adverse event, etc.		tion cannot be used (i.e. contraindication,
Q6. If diagnosis is OTHER, ple	ase specify below:	
Q7. Please indicate the Prescribe	r's specialty:	
☐ Oncologist	☐ Urologist	☐ None of the above



Xtandi-2 Medicare

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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process.

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



Xuriden-1 Medicare

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

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



Xuriden-1 Medicare

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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process.

Patient Name	Prescriber Name	
i aliciil Nailic.	i i escibei italiie.	

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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

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	



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



Yonsa-1 Medicare

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

Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process.

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



Zejula-1 Medicare

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

Patient Name:	Prescriber Name:		
Member/Subscriber Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Group Number:	NPI:	State Lic ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
imary 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 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	erany	
Q2. If the request is for CONTINUING THERAPY	, please provide the start dat	e (MM/YY):	
Q3. Please indicate the patient's diagnosis for the re	equested medication:		
Ovarian cancer (recurrent, epithelial)			
Fallopian tube cancer (recurrent)			
☐ Primary peritoneal cancer (recurrent)			
☐ Other			
Q4. If the patient's diagnosis is OTHER, please s	pacify halow:		
Q4. If the patient's diagnosis is Official, piease s	pecity below.		
Q5. Has the patient had a complete or partial respor	nse to platinum-based chemo	therapy?	
☐ Yes	☐ No		
Q6. Is Zejula being prescribed by (or in consultation	with) an oncologist or gynec	ologist?	
☐ Yes	□ No		
□ 169			
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:			
mary 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 for this patient that may support approval. Please answer the following questions and sign.				
ioliowing qu	lestions 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			
	<del></del>			



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	<b>9</b> :
Prescriber Signature		Date