ENTERAL/NUTRITIONAL SUPPLEMENTS
PRIOR AUTHORIZATION REQUEST FORM
Magnolia Health

FAX this completed form to 866-399-0929

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

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

I. Provider Information		**II. Member Information**
Prescriber name (print):		Member name:
Prescriber specialty:		Medicaid Identification number:
Phone:	Fax:	Date of Birth:
Office Contact Name:		Medication allergies:

III. Dispensing Pharmacy Information	
Dispensing Pharmacy:	
Phone:	Fax:

IV. Product/Clinical Information		
Product name and strength:	Daily Dose:	Quantity/Month:
Diagnosis relevant to ***this*** request:		
Expected length of therapy:		
Method of Administration ☐ Oral (By Mouth) ☐ Tube Feeding ☐ Other:		

I hereby certify that I am the ordering physician/nurse practitioner/physician assistant identified in the form and I deem the prescribed medication to be necessary for the patient listed. I understand that and falsification, omission or concealment of material fact may subject me to civil penalties, fines or criminal prosecution.

Provider Signature:	Date: