SPECIALTY PHARMACY PRIOR AUTHORIZATION FORM

MAGNOLIA HEALTH, MISSISSIPPI

FAX this completed form to 1-855-678-6976

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

Specialty Pharmacy Provider Ship to: ☐ Patient ☐ Office ☐ Other: _____

Name of Specialty Pharmacy Provider: _____

MEMBER INFORMATION

Patient Name: _____
Address: _____
City, State Zip: _____
Home Phone: _____
Alternate Phone: _____
Date of Birth: _____
Gender: _____

PROVIDER INFORMATION

Prescriber Name: _____
NPI#: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____
Fax: _____
Contact Name: _____

INSURANCE INFORMATION

Primary Insurance: _____ ID#: _____ Phone#: _____
Secondary Insurance: _____ ID#: _____ Phone#: _____

DIAGNOSIS

Please include ICD9 and description

_____
_____
_____
_____
_____

Date of Diagnosis: _____

(Please include any diagnostic clinicals such as labs, radiology, exams, etc.)

ADDITIONAL CLINICAL INFORMATION

Weight: _____ kg/lbs
Height: _____ in/cm
Lab Data *(Please include copies of reports)*: _____
_____
Other Medications: _____
_____
Additional Comments: _____
_____

Is member currently treated with this medication(s)? No ___ Yes ___How long: _____
Is this request a continuation of a previous approval by Magnolia Health Plan? No ___Yes ___
Has the strength, dosage or quantity required per day: Increased _____ Decreased _____ Same _____

MEDICATION(S) REQUESTED

Therapy Start Date: _____

Medication Name	Strength/Dose	Directions	Quantity	Refills

_____ _____
Prescriber's Signature Date

Envolve Pharmacy Solutions will respond via fax or phone within 24 hours of receipt of all necessary information, except during weekends and holidays. Requests for prior authorization (PA) must include member name, ID#, and drug name. **Incomplete forms will delay processing**.