

# Confidential

2181 E Aurora Rd Ste 201  
Twinsburg OH 44087

Phone: 330-405-8080  
Fax: 330-405-8081

**Envision/Rx Options, Inc.**

**To:** **From:** Envision Rx Options Clinical Staff

**Fax:** **Pages:**

**Phone:** **Date:**

**Re:** ***Prior Authorization Request for  
Elderplan Member***

*Dear Provider,*

*Envision Rx Options/Elderplan requires a Prior Authorization for certain medications for its members. Attached is a Prior Authorization form for Elderplan Member: \_\_\_\_\_*

*Please complete the form and fax back to **330-405-8081** attn: **Clinical Dept***

*Comments:*

*Thank you,  
The Clinical Staff  
Envision Pharmaceutical Services*

**Privacy & Confidentiality of Information Notice:** This communication may contain non-public, confidential, or legally privileged information intended for the sole use of the designated recipient(s) named above. If you are not the intended recipient of this facsimile, or the employee or agent responsible for delivering it to the intended recipient you are hereby notified that any dissemination or copying of this facsimile is strictly prohibited. If you receive this facsimile in error, please notify us by telephone and return the original facsimile to us at the above address via the United States mail. If you are the intended recipient, you must secure the contents in accordance with all applicable state or federal requirements related to the privacy and confidentiality of information, including the HIPAA Privacy guidelines

**FOR ENVISION INTERNAL USE ONLY:  
Date and Time Received Completed form from Doctor**

# ENVISION RX OPTIONS/ELDERPLAN Drug Prior Authorization Request

**IMPORTANT INFORMATION REQUIRED - FORM CANNOT BE PROCESSED WITHOUT REQUIRED SUPPORTING CLINICAL STATEMENT AND RELEVANT LAB VALUES\*\***

A separate request must be completed for each drug for each patient.

Patient Information			Physician Information	
Patient Name			Name:	
Member ID#	Group#	Carrier	Office Phone:	
Sex: M <input type="checkbox"/> F <input type="checkbox"/>		Date of Birth:	Secure Office Fax Number:	
Office Contact Name:			NPI #	

Drug Name :								
Dose:	Directions:			Quantity:				
Initial Therapy ?	Y	N	Continuing Therapy ?	Y	N	Has Dose Been Titrated?	Y	N
Anticipated Duration of Therapy:		Diagnosis/Indication(s):						

**\*\*Prior Formulary alternative treatment(s) provided for this condition:** \_\_\_\_\_

**\*\*Supporting Clinical Statement** (such as applicable protocols or guidelines followed, contraindications, drug allergies, dialysis, or any other additional clinical information to support medication request):

**Relevant Lab Values:** \_\_\_\_\_

**Expedited Review (24 hours):** The 72 hour standard review may seriously jeopardize the health or life of the member or the member's ability to regain maximum function (please explain above).

Fax to **1-330-405-8081** or mail to: Envision 2181 East Aurora Road Suite 201 Twinsburg, OH 44087  
You will be notified within 72 hrs whether the request was approved. For inquiries, call 1-866-417-3064 (TTY 1-866-763-9630)

**Information on this form is protected health information and subject to all privacy and security regulations under HIPAA.**

<p><b>FOR ENVISION INTERNAL USE ONLY –</b></p> <p><b>Sender Information:</b></p> <p><b>Reviewed by:</b> _____</p> <p>Approved Denied Date: _____ Time: _____ am pm</p> <p><b>Date and Time of Communication to Pharmacy</b> _____</p>
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