envolve™ Pharmacy Solutions

Allergen Extracts
Prior Authorization Request Form
(*Do not use this form for biopharmaceutical products*)

superior healthplan™

Fax this completed form to 1-866-399-0929
OR Mail requests to: Envolve Pharmacy Solutions PA Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720
Call 1-800-460-8988 to request a 72-hour supply of medication.

I. Provider Information		**II. Member Information**
Prescriber name (print):		Member name:
Prescriber specialty:		Identification number:
Fax:	Phone:	Date of birth:
Office contact name:		Medication allergies:

III. Drug Information *(One drug request per form)*

Drug name and strength:	Dosage form:	Dosage interval (sig):	Qty per day:

Diagnosis relevant to ***this*** request:

Current Procedural Terminology (CPT) relevant to ***this*** request:

- ☐ 86003 – ALLERGEN SPECIFIC IGE; QUANTITATIVE OR SEMIQUANTITATIVE, EACH ALLERGEN
- ☐ 86005 – ALLERGEN SPECIF IGE; QUALITATIVE, MULTI ALLERGEN SCREEN
- ☐ 82785 – TOTAL QUANTITATIVE IGE
- ☐ 83518 – TOTAL QUALITATIVE IGE
- ☐ 95004 – PERCUTANEOUS TESTS WITH ALLERGENIC EXTRACTS, IMMEDIATE TYPE REACTION, INCLUDING TEST INTERPRETATION AND REPORT
- ☐ 95024 – INTRACUTANEOUS (INTRADERMAL) TESTS WITH ALLERGENIC EXTRACTS, IMMEDIATE TYPE REACTION, INCLUDING TEST INTERPRETATION AND REPORT
- ☐ 95027 – INTRACUTANEOUS (INTRADERMAL) TESTS, SEQUESNTIAL AND INCREMENTAL, WITH ALLERGENIC EXTRACTS FOR AIRBORNE ALLERGENS, IMMEDIATE TYPE REACTION, INCLUDING TEST INTERPRETATION AND REPORT
- ☐ 95028 – INTRACUTANEOUS (INTRADERMAL) TESTS WITH ALLERGENIC EXTRACTS, DELAYED TYPE REACTION, INCLUDING READING

Expected length of therapy:

IV. Medication History for this Diagnosis

A. Is member currently treated on this medication?
☐ Yes; How long?_____[go to item B] ☐ No [skip items B & C; go to item D]

B. Is this request for continuation of a previous approval?
☐ Yes [go to item C] ☐ No [skip item C; go to item D]

C. Has strength, dosage, or quantity required per day increased or decreased?
☐ Yes [go to item D] ☐ No [skip item D; indicate rationale for continuation in Section IV and submit form]

D. Please indicate previous treatment and outcomes below.

Drug Name (include strength and dosage)	Dates of Therapy	Reason for Discontinuation
1		
2		
3		
4		

NOTE: Confirmation of use will be made from member history on file; prior use of preferred drugs is a part of the exception criteria.

V. Rationale for Request / Pertinent Clinical Information (Required for all Prior Authorizations)

Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	Provider signature:	Date:

US Script 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**. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.).

Revised 06 2015