PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

EIC Ticlopidine HRM PA

Phone: 866-250-2005 Fax back to: 877-503-7231 Or

Complete this form online at https://envision.promptpa.com/

ENVISION RX OPTIONS 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 Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State, Zip:	City, State, Zip:	
Member Phone:		

Drug Name: ☐ Expedited/Urgent

Directions:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign:

Q1. Is the request for initial or continuing therapy?

☐ Initial

☐ Continuation (Start date mm/yy:)

Q2. Please indicate the diagnosis for which the requested medication is being prescribed:

☐ Stroke

☐ Stent thrombosis, adjunctive therapy

☐ Other (please complete question 3)

Q3. If the diagnosis is other, please specify:

Q4. Is the patient greater than or equal to 65 years of age?

☐ Yes ☐ No

Q5. Has the patient had an inadequate response, intolerable side effect, or contraindication to any of the following formulary non-high-risk medication (HRM) alternatives (check all that apply):

☐ clopidogrel (Plavix)

☐ Other (please specify:)

Q6. The drug being requested is on formulary but requires prior authorization for individuals 65 years of age and over as itis often considered unsafe for administration to these individuals. Does the prescriber attest to the medical necessity for using this high risk medication?

☐ Yes ☐ No

Q7. Please provide monitoring plan for adverse side effects for use of this medication in patient 65 years of age and older:

Q8. What is the anticipated treatment course/duration of treatment with this medication?

Q9. Prescriber may provide any supporting clinical statements (such as chart notes, lab values, adverse outcomes,

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Patient Name:	**Prescriber Name:**

treatment failures, or any other additional clinical information to support this request):

Physician Signature **Date**

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