Dear Prescriber,

NextLevel Health (NLH) is committed to improving the health of the Cook County community. Our approach is simple…to provide needed access to care and support services to our members within their communities and homes.

Our mission is to effectively manage the health and wellness of our members through strong partnerships, defined care workflows, and a focus on anticipatory management of health concerns and conditions through a coordinated approach.

From time to time, NLH reviews its contracts with vendors. NLH is pleased to announce it will be moving to a new pharmacy benefits manager (PBM), **Envolve Pharmacy Solutions (EPS)**, **starting January 1, 2018**. EPS is the one of the largest Medicaid PBMs in the country.

What this means for you:

1. New PA fax form (attached)
2. New PBM numbers
   a. **EPS Phone: 866-399-0928**
   b. **EPS Fax: 866-399-0929**

NLH has also completed a thorough review of its formulary and has adopted a **new formulary** changes. The new formulary can be found on the NLH website: https://nextlevelhealthil.com/pdl/ after January 1, 2018.

To decrease member disruption, **most members should continue to receive the same medications for the first 90 days of 2018.** Individualized information regarding medications changes will be sent at a later date. All previously approved prior authorizations will not be affected.

As a reminder, the State of Illinois will be going to a statewide PDL starting July 1, 2018 for all Medicaid plans. More information will be provided as it becomes available.

If you have any questions, please do not hesitate to contact us: 844-807-9734.

Thank you

NextLevel Health Partners

NextLevelHealth
A healthier you. A healthier community.

Medication Prior Authorization Request

NEXTLEVEL HEALTH

Phone: 866-399-0928 Fax: 866-399-0929

envolve
Pharmacy Solutions

Instructions:

1. Fill out all fields.
2. Fax completed form to the number above.
3. Please write legibly.
4. Only 1 medication per form.

Date of Request:	

Patient Information	**Prescriber Information**
Patient Name:	Prescriber Name and Specialty:
Member ID #:	NPI #:
Sex: ☐ Male ☐ Female	Office Phone:
Date of Birth:	Office Fax:
Patient Phone:	Contact Person:

Diagnosis and Medical Information		
Medication:	Strength & Route of Administration:	Frequency:
Height & Weight:	Expected Length of Therapy:	Quantity:

Diagnosis Related to Medication Request:	
Drug Allergies:	

Has the member taken this medication before?		If yes, what dose/strength? For how long?	

Rationale for Prior Authorization

History of a medical condition, allergies or other pertinent information requiring the use of this medication:

Previous medications tried and failed for this condition		
Name/Strength of Medication	Reason for Failure	Date(s) of Failure

Include the pertinent laboratory results to ensure a complete PA review.

Prescriber's Signature:	Date:

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