



Molina® Healthcare of New Mexico, Inc.

Prior Authorization Request Form

Medical/Behavioral Health/Pharmacy

<p>To file electronically, send to:</p> <p>Healthcare Services: https://provider.molinahealthcare.com/provider/login</p> <p>Pharmacy: https://www.covermymeds.com/ https://surescripts.com/</p>	<p>To file via facsimile, send to:</p> <p>For Medicaid: Healthcare Services: 1-833-558-6769 Pharmacy : 1-866-472-4578</p> <p>For Marketplace: Pharmacy 1-866-472-4578 Healthcare Services: 1-833-322-1061</p>	<p>To contact the coverage review team for Pharmacy and Healthcare Services, please call:</p> <p>1-855-322-4078</p> <p>Monday through Friday between the hours of 8am and 5pm MST.</p> <p>For after-hours review, please contact:</p> <p>1-855-322-4078</p>
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MEMBER INFORMATION

Date of Request:			
Health Plan:			
Enrollee Information:		DOB (MM/DD/YYYY):	
Member ID#:		Member Phone:	
Street Address:			
City, State, Zip Code			
Priority and Frequency:	<input type="checkbox"/> Non-Urgent/Routine/Elective <input type="checkbox"/> Urgent/Expedited – Clinical Reason for Urgency Required: _____ <input type="checkbox"/> Emergent Inpatient Admission		

PROVIDER INFORMATION

Please note: processing delays may occur if rendering provider does not have appropriate documentation of medical necessity. Ordering provider may need to initiate prior authorization.

REQUESTING PROVIDER / FACILITY:

Provider Name:		NPI#:	TIN#:	
Phone:	FAX:	Email:		
Address:	City:	State:	Zip:	
PCP Name:		PCP Phone:		
Office Contact Name:		Office Contact Phone:		

SERVICING PROVIDER / FACILITY:

Provider/Facility Name (Required):				
NPI#:	TIN#:	Medicaid ID# (If Non-Par):	<input type="checkbox"/> Non-Par <input type="checkbox"/> COC	
Phone:	FAX:	Email:		
Address:	City:	State:	Zip:	

PLEASE SEND CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION

MEDICAL REFERRAL/SERVICE TYPE REQUESTED

Request Type:	<input type="checkbox"/> Initial Request	<input type="checkbox"/> Extension/ Renewal / Amendment	Previous Auth#:
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Inpatient Services: <input type="checkbox"/> Inpatient Hospital <input type="checkbox"/> Inpatient Transplant <input type="checkbox"/> Inpatient Hospice <input type="checkbox"/> Long Term Acute Care (LTAC) <input type="checkbox"/> Acute Inpatient Rehabilitation (AIR) <input type="checkbox"/> Skilled Nursing Facility (SNF) <input type="checkbox"/> Other Inpatient: _____	Outpatient Services: <input type="checkbox"/> Chiropractic <input type="checkbox"/> Dialysis <input type="checkbox"/> DME <input type="checkbox"/> Genetic Testing <input type="checkbox"/> Home Health <input type="checkbox"/> Hospice <input type="checkbox"/> Hyperbaric Therapy <input type="checkbox"/> Imaging/Special Tests	<input type="checkbox"/> Office Procedures <input type="checkbox"/> Infusion Therapy <input type="checkbox"/> Laboratory Services <input type="checkbox"/> LTSS Services <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Outpatient Surgical/Procedures <input type="checkbox"/> Pain Management <input type="checkbox"/> Palliative Care	<input type="checkbox"/> Pharmacy <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Radiation Therapy <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Transplant/Gene Therapy <input type="checkbox"/> Transportation <input type="checkbox"/> Wound Care <input type="checkbox"/> Other: _____
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HCPCS/CPT/CDT/Primary ICD-10/Code:	Description:
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DATES OF SERVICE		PROCEDURE/ SERVICE CODES	DIAGNOSIS CODE	REQUESTED SERVICE	REQUESTED UNITS/VISITS
START	STOP				



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BEHAVIORAL HEALTH REFERRAL/SERVICE TYPE REQUESTED

Request Type:	<input type="checkbox"/> Initial Request	<input type="checkbox"/> Extension/ Renewal / Amendment	Previous Auth#:
Inpatient Services:	Outpatient Services:		
<input type="checkbox"/> Inpatient Psychiatric <input type="checkbox"/> Involuntary <input type="checkbox"/> Voluntary <input type="checkbox"/> Inpatient Detoxification <input type="checkbox"/> Involuntary <input type="checkbox"/> Voluntary If Involuntary, Court Date: _____	<input type="checkbox"/> Residential Treatment <input type="checkbox"/> Partial Hospitalization Program <input type="checkbox"/> Intensive Outpatient Program <input type="checkbox"/> Day Treatment <input type="checkbox"/> Assertive Community Treatment Program <input type="checkbox"/> Targeted Case Management		<input type="checkbox"/> Electroconvulsive Therapy <input type="checkbox"/> Psychological/Neuropsychological Testing <input type="checkbox"/> Applied Behavioral Analysis <input type="checkbox"/> Non-PAR Outpatient Services <input type="checkbox"/> Other: _____

HCPCS/CPT/CDT/Primary ICD-10/Code:		Description:			
DATES OF SERVICE START	STOP	PROCEDURE/ SERVICE CODES	DIAGNOSIS CODE	REQUESTED SERVICE	REQUESTED UNITS/VISITS

PRESCRIPTION DRUG

Diagnosis name and Primary ICD-10 code: _____

Patient Height (if required): _____	Patient Weight (if required): _____
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Route of administration: Oral/SL Topical Injection IV Other: Explain: _____

Administered: Doctor's Office Dialysis Center Home Health/Hospice By Patient

MEDICATION REQUESTED	STRENGTH (INCLUDE BOTH LOADING AND MAINTENANCE DOSAGE)	DOSING SCHEDULE (INCLUDING LENGTH OF THERAPY)	QUANTITY PER MONTH OR QUANTITY LIMITS

Is the patient currently treated with the requested medication(s)? : Yes* No
 *If "Yes", when was the treatment with the requested medication started? Date: _____

Anticipated medication start date (MM/DD/YY): _____

General prior authorization request. Explain the clinical reason(s) for the requested medications, including an explanation for selecting these medications over alternatives:

Rationale for drug formulary or step-therapy exception request:

Alternate drug(s) contraindicated or previously tried, but with adverse outcome, e.g., toxicity, allergy, or therapeutic failure, specify below: (1) Drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s).

Patient is stable on current drug(s), high risk of significant adverse clinical outcome with medication change. Specify anticipated significant adverse clinical outcome below.

Medical need for different dosage and/or higher dosage, specify below: (1) Dosage(s) tried; (2) explain medical reason.

Request for formulary exception, specify below: (1) Formulary or preferred drugs contraindicated or tried and failed, or tried and not as effective as requested drug; (2) if therapeutic failure, length of therapy on each drug and adverse outcome; (3) if not as effective, length of therapy on each drug and outcome.

Other (explain below)

Required explanation(s):

List any other medications patient will use in combination with requested medication:

List any known drug allergies

Previous services/therapy (including drug, dose, duration, and reason for discontinuing each previous service/therapy)

Date Discontinued:

Date Discontinued:

Date Discontinued:

Attestation

I hereby certify and attest that all information provided as part of this prior authorization request is true and accurate.

Requester Signature:

Date:

DO NOT WRITE BELOW THIS LINE, FIELDS TO BE COMPLETED BY PLAN

Authorization #

Contact Name _

Contact's credentials/designation