Molina® Healthcare of New Mexico, Inc.
Prior Authorization Request Form
Medical/Behavioral Health/Pharmacy

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

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:	☐ Non-Urgent/Routine/Elective ☐ Urgent/Expedited – Clinical Reason for Urgency **Required**:_____ ☐ 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):**	☐ **Non-Par** ☐ **COC**
Phone:	**FAX:**	**Email:**	
Address:	**City:**	**State:**	**Zip:**

PLEASE SEND CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION

MEDICAL REFERRAL/SERVICE TYPE REQUESTED

Request Type:	☐ **Initial Request**	☐ **Extension/ Renewal / Amendment**	**Previous Auth#:**

Inpatient Services:	**Outpatient Services:**		
☐ Inpatient Hospital ☐ Inpatient Transplant ☐ Inpatient Hospice ☐ Long Term Acute Care (LTAC) ☐ Acute Inpatient Rehabilitation (AIR) ☐ Skilled Nursing Facility (SNF) ☐ Other Inpatient:_____	☐ Chiropractic ☐ Dialysis ☐ DME ☐ Genetic Testing ☐ Home Health ☐ Hospice ☐ Hyperbaric Therapy ☐ Imaging/Special Tests	☐ Office Procedures ☐ Infusion Therapy ☐ Laboratory Services ☐ LTSS Services ☐ Occupational Therapy ☐ Outpatient Surgical/Procedures ☐ Pain Management ☐ Palliative Care	☐ Pharmacy ☐ Physical Therapy ☐ Radiation Therapy ☐ Speech Therapy ☐ Transplant/Gene Therapy ☐ Transportation ☐ Wound Care ☐ Other: _____.

HCPCS/CPT/CDT/Primary ICD-10/Code: **Description:**

DATES OF SERVICE		**PROCEDURE/ SERVICE**	**DIAGNOSIS CODE**	**REQUESTED**	**REQUESTED**
START	**STOP**	**CODES**		**SERVICE**	**UNITS/VISITS**

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BEHAVIORAL HEALTH REFERRAL/SERVICE TYPE REQUESTED

Request Type:	☐ **Initial Request**	☐ **Extension/ Renewal / Amendment**	**Previous Auth#:**

Inpatient Services:	**Outpatient Services:**	
☐ Inpatient Psychiatric ☐ Involuntary ☐Voluntary ☐ Inpatient Detoxification ☐ Involuntary ☐Voluntary If Involuntary, Court Date:_____	☐ Residential Treatment ☐ Partial Hospitalization Program ☐ Intensive Outpatient Program ☐ Day Treatment ☐ Assertive Community Treatment Program ☐ Targeted Case Management	☐ Electroconvulsive Therapy ☐ Psychological/Neuropsychological Testing ☐ Applied Behavioral Analysis ☐ Non-PAR Outpatient Services ☐ Other: _____

HCPCS/CPT/CDT/Primary ICD-10/Code: **Description:**

DATES OF SERVICE START	DATES OF SERVICE 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):**

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) tired; (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