NEW MEXICO UNIFORM PRIOR AUTHORIZATION FORM

To file electronically, send to:	**To file via facsimile, send to:**
https://provider.molinahealthcare.com/provider/login	Pharmacy 1-866-472-4578 Healthcare Services 1-833-322-1061 (updated 5/1/21)

To contact the coverage review teams for Pharmacy and Healthcare Services departments, please call 1-855-322-4078, Monday through Friday between the hours of 8am and 5pm MST. For after-hours review, please call 1-855-322-4078.

[1] Priority and Frequency

a. Standard [ ] Services scheduled for this date:	**b. Urgent/Expedited [ ]** Provider certifies that applying the standard review timeline may seriously jeopardize the life or health of the enrollee.

c. Frequency Initial [ ] Extension [ ] Previous Authorization #

[2] Enrollee Information

a. Enrollee name:	**b. Enrollee date of birth:**	**c. Subscriber/Member ID #:**
d. Enrollee street address:		
e. City:	**f. State:**	**g. Zip code:**

[3] Provider Information: Ordering Provider [ ] Rendering Provider [ ] Both [ ]

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.

a. Provider Name:	**b. Provider type/specialty**	**c. Administrative contact:**
d. NPI #:	**e. DEA # if applicable:**	
f. Clinic/facility name:	**g. Clinic/pharmacy/facility street address:**	
h. City, State, Zip code:	**i. Phone number and ext.:**	**j. Facsimile/Email:**

[4] Requested medical or behavioral health course of treatment/procedure/device information (skip to Section 8 if drug requested)

a. Service description:

b. Setting/CMS POS code: Outpatient [ ] Inpatient [ ] Home [ ] Office [ ] Other* [ ]

c. *Please specify if Other:

[5] HCPCS/CPT/ICD-10 CODES

a. Latest ICD-10 Code	b. HCPCS/CPT/CDT Code	c. Medical Reason

[6] Frequency/Quantity/Repetition Request

a. Does this service involve multiple treatments? Yes [ ] No [ ] If "No", skip to Section 7.

b. Type of Service:	**c. Name of therapy/agency:**
d. Units/Volume/Visits requested:	**e. Frequency/length of time needed:**

[7] Prescription Drug

a. Diagnosis name and code:

b. Patient Height (if required):	**c. Patient Weight (if required):**

d. Route of administration: Oral/SL [ ] Topical [ ] Injection [ ] IV [ ] Other* [ ]

***Explain if "Other":**

e. Administered: Doctor's office [ ] Dialysis Center [ ] Home Health/Hospice [ ] By patient [ ]

f. Medication Requested	g. Strength (include both loading and maintenance dosage)	h. Dosing Schedule (including length of therapy)	i. Quantity per month of Quantity Limits

If "Yes", when was the treatment with the requested medication started? Date:

k. Anticipated medication start date (MM/DD/YY):

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

m. Rationale for drug formulary or step therapy exception request)? Is the patient currently treated with the requested medication(s)? Yes* [ ] No [ ]

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):

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

o. List any known drug allergies:

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

a.	**Date Discontinued:**
b.	**Date Discontinued:**
c.	**Date Discontinued:**

[9] 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 _____