

**REFER TO MOLINA'S PROVIDER WEBSITE OR PRIOR AUTHORIZATION LOOK UP TOOL/MATRIX FOR
SPECIFIC CODES THAT REQUIRE AUTHORIZATION
ONLY COVERED SERVICES ARE ELIGIBLE FOR REIMBURSEMENT**

Prior authorization is not required for New Mexico Gold Card Providers. ONLY for the specific codes determined to be exempt for each individual provider.

**OFFICE VISITS TO CONTRACTED/PARTICIPATING (PAR) PROVIDERS & REFERRALS TO NETWORK SPECIALISTS
DO NOT REQUIRE PRIOR AUTHORIZATION. EMERGENCY SERVICES
DO NOT REQUIRE PRIOR AUTHORIZATION.**

- **Advanced Imaging and Specialty Tests**
- **Behavioral Health, Mental Health, Alcohol and Chemical Dependency Services:**
 - Inpatient, Transitional Residential Treatment for Substance Use, Partial Hospitalization, Day Treatment
 - Intensive Outpatient above 16 units
 - Electroconvulsive Therapy (ECT) and Transcranial Magnetic Stimulation (TMS)
 - Applied Behavioral Analysis (ABA) – for treatment of Autism Spectrum Disorder (ASD).
- **Cosmetic, Plastic and Reconstructive Procedures** No PA required with Breast Cancer Diagnoses.
- **Durable Medical Equipment**
- **Elective Inpatient Admissions:** Acute Hospital, Skilled Nursing Facilities (SNF), Acute Inpatient Rehabilitation, Long Term Acute Care (LTAC) Facilities
- **Experimental/Investigational Procedures**
- **Genetic Counseling and Testing** (Except for prenatal diagnosis of congenital disorders of the unborn child through amniocentesis and genetic test screening of newborns or as otherwise mandated by state regulations).
- **Healthcare Administered Drugs**
- **Home Healthcare Services (including home-based PT/OT/ST)**
- **Hyperbaric/Wound Therapy**
- **Inpatient Hospitalization and NICU Admissions:** (Except emergency services)
- **Long Term Services and Supports (LTSS):** Not a covered benefit.
- **Miscellaneous & Unlisted Codes:** Molina requires standard codes when requesting authorization. Should an unlisted or miscellaneous code be requested, medical necessity documentation and rationale must be submitted with the prior authorization request.
- **Neuropsychological and Psychological Testing**
- **Non-Par Providers/Facilities:** With the exception of some facility based professional services, receipt of ALL services or items from a non-contracted provider in all places of service require approval.
 - Local Health Department (LHD) services;
 - Hospital Emergency services
 - Evaluation and Management services associated with inpatient, ER, and observation stay, or
 - facility stay (POS 21, 22, 23, 31, 32, 33, 51, 52, 61)
 - Radiologists, anesthesiologists, and pathologists' professional services when billed in POS 19, 21, 22, 23, 24, 51, 52;
 - Other services based on State requirements.
- **Occupational, Physical & Speech Therapy:** After the first 12 visits for PT/OT or first 6 visits for ST
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures**
- **Pain Management Procedures**
- **Prosthetics/Orthotics**
- **Radiation Therapy and Radiosurgery**
- **Sleep Studies**
- **Transplants including Solid Organ and Bone Marrow** (Cornea transplant does not require authorization).
- **Transportation:** All non-emergent transportation.
- **Vision:** Pediatric Low Vision Optical Devices and Services: Please contact VSP (Vision Service Plan) at 1 (800) 877-7195 or visit their website at www.vsp.com/advantage

IMPORTANT INFORMATION FOR MOLINA HEALTHCARE MARKETPLACE PROVIDERS

Information generally required to support authorization decision making includes:

- Current (up to 6 months), adequate patient history related to the requested services.
- Relevant physical examination that addresses the problem.
- Relevant lab or radiology results to support the request (including previous MRI, CT, Lab, or X-ray report/ results).
- Relevant specialty consultation notes.
- Any other information or data specific to the request.

The Urgent / Expedited service request designation should only be used if the treatment is required to prevent serious deterioration in the member’s health or could jeopardize their ability to regain maximum function. Requests outside of this definition will be handled as routine / non-urgent.

- If a request for services is denied, the requesting provider and the member will receive a letter explaining the reason for the denial and additional information regarding the grievance and appeals process. Denials also are communicated to the provider by telephone, fax, or electronic notification. Verbal, fax, or electronic denials are given within one business day of making the denial decision or sooner if required by the member’s condition.
- Providers and members can request a copy of the criteria used to review requests for medical services.
- Molina Healthcare has a full-time Medical Director available to discuss medical necessity decisions with the requesting physician at (855) 322-4078.

Important Molina Healthcare Marketplace Contact Information

New Mexico: A registered professional nurse or physician is available by telephone seven days a week, 24 hours a day, to render utilization management determinations for providers or to respond to inquiries concerning emergency or urgent care.

Prior Authorizations including Behavioral Health

Authorizations:

Phone: (855) 322-4078

Fax: (833) 322-1061

Vision:

Phone: (800) 877-7195

Website: www.vsp.com/advantage

Pharmacy Authorizations:

Phone: (855) 322-4078

Fax: (866) 472-4578

Member Customer Service, Benefits/Eligibility:

Phone: (888) 295-7651/ TTY/TDD 711

Radiology Authorizations:

Phone: (855) 714-2415

Fax: (877) 731-7218

Provider Customer Service:

Phone: (855) 322-4078

Available 24 hours, 7 days/week for emergent PA requests

Transplant Authorizations:

Phone: (855) 714-2415

Fax: (877) 813-1206

24 Hour Nurse Advice Line (7 days/week)

Phone: (888) 275-8750/TTY: 711

Members who speak Spanish can press 1 at the IVR (Interactive Voice Response) prompt. The nurse will arrange for an interpreter, as needed, for non-English/Spanish speaking members.

No referral or prior authorization is needed.

Providers may utilize Molina Healthcare’s Website at: <https://provider.molinahealthcare.com/Provider/Login>

Available features include:

- | | |
|---------------------------------------|----------------------------------|
| • Authorization submission and status | ◆ Claims submission and status |
| • Member Eligibility | ◆ Download Frequently used forms |
| • Provider Directory | ◆ Nurse Advice Line Report |



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

MEMBER INFORMATION

To file electronically, send to:

<https://provider.molinahealthcare.com/provider/login>

Date of Request:

To file via facsimile, send to: Pharmacy 1-866-472-4578 Healthcare Services 1-833-322-1061

To contact the coverage, review team for Molina Healthcare of New Mexico Pharmacy and Healthcare Services, please call 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.

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#:
Inpatient Services:	Outpatient 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: _____	<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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Prior Authorization Request Form
Medical/Behavioral Health/Pharmacy

BEHAVIORAL HEALTH REFERRAL/SERVICE TYPE REQUESTED

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

Inpatient 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: _____	Outpatient Services: <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: _____
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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):** _____

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:



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

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