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:		
Member Name		**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**:_____ **Provider certifies that applying the standard review timeline may seriously jeopardize the life or health of the member.* ☐ Emergent Inpatient Admission	

PROVIDER INFORMATION

Please note: Processing delays may occur if **servicing provide**r does not have appropriate documentation of medical necessity. **Ordering provider** may need to initiate prior authorization.

ORDERING PROVIDER / FACILITY:

Provider Name:				
NPI#:	**TIN#:**	**DEA# if applicable:**	☐ **Non-Par** ☐**COC**	
		Medicaid ID# (If Non-Par):		
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#:**	**DEA# if applicable:**	☐ **Non-Par** ☐**COC**	
		Medicaid ID# (If Non-Par):		
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 CODES**	**PROCEDURE / SERVICE CODE DESCRIPTION**	**DIAGNOSIS CODE**	**REQUESTED UNITS/ NUMBER OF VISITS/FREQUENCY**
START	**STOP**				

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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		PROCEDURE/ SERVICE CODES	PROCEDURE / SERVICE CODE DESCRIPTION	DIAGNOSIS CODE	REQUESTED UNITS/ NUMBER OF VISITS/FREQUENCY
START	STOP				

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):

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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) used (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