

# Molina® Healthcare of New Mexico, Inc.

## Prior Authorization Request Form

### Medical/Behavioral Health/Pharmacy

<b>To file electronically, send to:</b>  <b>Healthcare Services:</b> <a href="https://provider.molinahealthcare.com/provider/login">https://provider.molinahealthcare.com/provider/login</a>  <b>Pharmacy:</b> <a href="https://www.covermymeds.com/">https://www.covermymeds.com/</a> <a href="https://surescripts.com/">https://surescripts.com/</a>	<b>To file via facsimile, send to:</b>  <b>For Medicaid:</b> Healthcare Services: 1-833-558-6769 Pharmacy: 1-866-472-4578 Progeny (NICU Admit): 1-866-484-6087  <b>For Marketplace:</b> Pharmacy 1-866-472-4578 Healthcare Services: 1-833-322-1061	To contact the coverage review team for 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  <b>To contact ProgenyHealth, please call:</b> 1-888-832-2006
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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:	<input type="checkbox"/> Non-Urgent/Routine/Elective  <input type="checkbox"/> Urgent/Expedited – *Clinical Reason for Urgency Required: _____ <i>*Provider certifies that applying the standard review timeline may seriously jeopardize the life or health of the member.</i>  <input type="checkbox"/> Emergent Inpatient Admission

PROVIDER INFORMATION	
<b><i>Please note:</i></b> Processing delays may occur if <b>servicing provider</b> does not have appropriate documentation of medical necessity. <b>Ordering provider</b> may need to initiate prior authorization.	
ORDERING PROVIDER / FACILITY:	
Provider Name:	
NPI#:	TIN#:
DEA# if applicable:	<input type="checkbox"/> Non-Par <input type="checkbox"/> 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:	<input type="checkbox"/> Non-Par <input type="checkbox"/> COC
Medicaid ID# (If Non-Par):	
Phone:	FAX:
Email:	
Address:	City:
State:	Zip:

PLEASE SEND CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION	
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## MEDICAL REFERRAL/SERVICE TYPE REQUESTED

<b>Request Type:</b>	<input type="checkbox"/> Initial Request	<input type="checkbox"/> Extension/ Renewal / Amendment	<b>Previous Auth#:</b>
<b>Inpatient Services:</b>		<b>Outpatient Services:</b>	
<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: _____ <small>*Note: Inpatient NICU Admission/Continued Stay should be faxed to 1-866-484-6087</small>		<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: _____	

**HCP/CS/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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### Medical/Behavioral Health/Pharmacy

#### BEHAVIORAL HEALTH REFERRAL/SERVICE TYPE REQUESTED

<b>Request Type:</b>	<input type="checkbox"/> Initial Request	<input type="checkbox"/> Extension/ Renewal / Amendment	<b>Previous Auth#:</b>
<b>Inpatient Services:</b>	<b>Outpatient Services:</b>		
<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		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:**

<b>Patient Height (if required):</b>	<b>Patient Weight (if required):</b>
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**Route of administration:**    Oral/SL    Topical    Injection    IV    Other: Explain:

<b>Administered:</b> <input type="checkbox"/> Doctor's Office <input type="checkbox"/> Dialysis Center <input type="checkbox"/> Home Health/Hospice <input type="checkbox"/> 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**