



PRIOR AUTHORIZATION REQUEST FORM For Medication

DATE OF REQUEST: _____ <u>MEMBER INFORMATION</u> NAME _____ ID # _____ BIRTHDATE _____ <input checked="" type="checkbox"/> PLEASE NOTE: By signing this form, you are attesting to the accuracy of the information provided, and that medical record documentation is available if requested.	<u>PROVIDER INFORMATION</u> NAME _____ NPI # _____ ADDRESS _____ _____ PHONE # _____ FAX # _____ CONTACT NAME _____ PROVIDER SIGNATURE _____
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Drug Requested: _____ **Dose/frequency:** _____

If *not* obtained at a pharmacy for self administration:
 Obtain at MVP's specialty pharmacy (CuraScript) for office administration (*may be required*)
 Office/Hospital/ Infusion Center: Place of Service _____
 Other _____

Diagnosis _____ **ICD-9 code** _____
 Please check one Initial Request Extension Request

Previous Medication History	Rationale for Discontinuation
Additional Information	

Rationale for Request (co-morbidities, allergies, etc.) _____

Submit chart notes to identify all of the following:

- All other treatments have been tried
- Outcome for each previous drug trial
- Expected duration of requested treatment
- All other pertinent information

PLEASE NOTE: ALL CHART NOTES/LAB REPORTS IN REFERENCE TO THIS REQUEST MUST BE RECEIVED BEFORE A REVIEW CAN BEGIN. REQUESTS SUBMITTED WITHOUT THIS DOCUMENTATION MAY BE DENIED.

Refer to the MVP Formulary at www.mvphealthcare.com for those drugs that require prior authorization or are subject to quantity limits or step therapy

FAX THIS REQUEST TO:

Commercial 1-800-376-6373 (HMO, EPO/PPO, Option Child, Healthy NY, Personal Plan, CompCare, ASO)	Medicare Part D 1-800-401-0915 (Preferred Gold, GoldAnywhere, GoldValue, USA Care)
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