PRIOR AUTHORIZATION REQUEST FORM for Medication

DATE OF REQUEST: ______________

MEMBER INFORMATION

NAME ____________________________________

ID # ____________________________________

BIRTHDATE ______________

☑ 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.

PROVIDER INFORMATION

NAME ____________________________________

NPI # ____________________________________

ADDRESS ____________________________________

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PHONE # ______________ FAX # ______________

CONTACT NAME ____________________________

PROVIDER SIGNATURE ______________________

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.)____________________________________

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Submit chart notes to identify all of the following:

- All other treatments have been tried
- Expected duration of requested treatment
- Outcome for each previous drug trial
- 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, MVP RxCare)

Effective June 2010