## **Prior Authorization Request**

## For Medical and Pharmacy Benefit Medications



## **Instructions for Completing this Request**

The prescriber responsible for the treatment and evaluation of the Member, or an authorized agent, may initiate a prior authorization or coverage determination by completing and submitting this Request form.

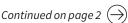
Prescribers with an online MVP Provider account may submit a Prior Authorization Request via the NovoLogix tool or by submitting this Request form to one of the numbers below. The NovoLogix online tool offers real-time determinations for specific requests. To access this tool, visit mvphealthcare.com/providers and sign in to your online account.

This completed Request form should be submitted with all supporting medical documentation and/or pertinent information to MVP Health Care via fax to one of the numbers below.

• For Medicare Advantage Plan Members, fax to 1-800-401-0915 • For all other Members, fax to 1-800-376-6373

For additional information on Formulary preferred medications, visit mvphealthcare.com/providers and select *Pharmacy*, then *MVP Formularies*.

Section 1: Clinical Urgency	(*Required Information)								
Does this Request require an expedited review?*  Yes (Initial review is completed within 24 hours of receiving the Request. Contact Phone No. must be included on page 2.)  No (Initial review is completed within 72 hours of receiving the Request.)  Section 2: MVP Member Information (*Required Information)									
Member Name*		Date of Birth*	MVP Member ID No.*	Phone No.					
Section 3: Medication and Administration Information (*Required Information)									
Medication (Name, strength, and dosage form)*		Directions'	Directions*						
If a name brand medication is requ Is this Request for a co-payment re Complete the following if the red	Yes No Yes No								
Where will the medication be administered?	Who will supply the medication?								
MD Office	MVP contracted Specialty Pharmacy  Prescribing Physician's office or another MD Office (Provide Name, NPI No., and Address below)								
Hospital	Outpatient Hospital/Infusion Center (Provide Name, NPI No., and Address below)								
Infusion Center Home	Home Care Company (Provide Name, NPI No., and Address below) Some MVP plans may have preferred vendors for select home infusion products.								
	Name			NPI No.					
	Address								



Health Insurance Portability and Accountability Act of 1996 (HIPAA).

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Member Name	MVP Member ID No.							
Section 4: Patient History	(*Required Information)							
Case Specific Diagnosis/ICD-10 Code(s)*								
Is this Request a continuation of therapy with thi	is medication?				Yes	No		
Has the patient experienced treatment failure or an adverse experience was preferred or formulary agent?			with Yes (provide the information below) No					
	<b>Approximate Period</b> Date Started Da	<b>of Therapy</b> te Stopped	Outcome					
Provide below any additional clinical informatio								
allergies, comorbidities, lab results, and specific								
Section 5: Prescribing Physician Information			(*Required Information)					
Prescribing Physician Name*	NPI N	o. <sup></sup>	Tax ID No.*		MMIS No. <sup>1</sup>			
Office Street Address*		City*		State	e*   Zip Cod	e <b>*</b>		
ffice Contact Name*		Office Co	Office Contact Phone No.*		ce Contact Fax No.*			
<sup>1</sup> Medicaid Management Information System (MMIS) No.	is only required for Medi	caid and Child He	ealth Plus Member requests.					
Section 6: Attestation and Signature					(*Required Inf	ormation)		
I attest that this information is accurate and true submitted without this documentation may be of statement that is material to a claim may be subj	lenied or delay the re lect to civil penalties	view process. I under both fed	understand that any per eral, and the New York St	son who knov ate False Clair	vingly makes ns Acts.			
By including my signature below, I attest that t	he information provi	ided in this Red	-	-	lge.			
Prescriber's Signature * Sign								