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*	Quantity*

If a name brand medication is requested, is a generic substitution allowed?* ☐ **Yes** ☐ **No**

Is this Request for a co-payment reduction? ☐ **Yes** ☐ **No**

Complete the following if the requested medication will *not* be obtained at a pharmacy for self-administration.

Where will the medication be administered?

- ☐ **MD Office**
- ☐ **Hospital**
- ☐ **Infusion Center**
- ☐ **Home**

Who will supply the medication?

- ☐ **MVP contracted Specialty Pharmacy**
- ☐ **Prescribing Physician's office or another MD Office** *(Provide Name, NPI No., and Address below)*
- ☐ **Outpatient Hospital/Infusion Center** *(Provide Name, NPI No., and Address below)*
- ☐ **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

Continued on page 2 →

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 this medication? ☐ **Yes** ☐ **No**

Has the patient experienced treatment failure or an adverse experience with a preferred or formulary agent? ☐ **Yes** *(provide the information below)* ☐ **No**

Drug, Dosage, and Frequency	**Approximate Period of Therapy** Date Started	Date Stopped	**Outcome**

Provide below any additional clinical information relevant to review this Request, including, but not limited to, patient height and weight, allergies, comorbidities, lab results, and specific medical needs. This information can also be provided as an attachment with this Request form.

Section 5: Prescribing Physician Information

*(*Required Information)*

Prescribing Physician Name*	NPI No.*	Tax ID No.*	MMIS No.[1]

Office Street Address*	City*	State*	Zip Code*

Office Contact Name*	Office Contact Phone No.*	Office Contact Fax No.*

[1]*Medicaid Management Information System (MMIS) No. is only required for Medicaid and Child Health Plus Member requests.*

Section 6: Attestation and Signature

*(*Required Information)*

I attest that this information is accurate and true, and that the appropriate supporting documentation is provided. I understand that requests submitted without this documentation may be denied or delay the review process. I understand that any person who knowingly makes a false statement that is material to a claim may be subject to civil penalties under both federal, and the New York State False Claims Acts.

By including my signature below, I attest that the information provided in this Request is true to the best of my knowledge.

*Prescriber's Signature** *Signature Date**