



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.

PRESCRIBING PHYSICIAN INFORMATION

NAME _____

NPI # _____

ADDRESS _____

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 (CVS Caremark) to be shipped to the office for administration

(Circle One) Office/Hospital/Infusion Center: Other _____

Facility Name _____

Facility NPI _____ Facility Address _____

Diagnosis _____ **ICD-10 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
- 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, Exchange, Medicaid, Child Health Plus, ASO)

Medicare Part D **1-800-401-0915**
(Preferred Gold, Gold PPO, GoldValue, BasiCare, USA Care, MVP RxCare)