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) for office administration *(may be required)*
□ (Circle One) Office/Hospital/Infusion Center: Other_____
□ Facility Name _____
□ Facility NPI _____ □ Facility Address _____

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
- 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)