Prior Authorization Request
For Prescriptions

Prescription requests may require prior authorization to be rendered.

For Medicare Advantage Plan Members, fax the completed form to **1-800-401-0915**. For all other Members, fax the completed for to **1-800-376-6373**. All supporting medical documentation and/or any additional pertinent information should be included when submitting this form.

Section 1: MVP Member Information *(*Required)*

Member Name *(first and last)** | Date of Birth* | MVP Member ID No.*

Section 2: Requesting Provider Information *(*Required)*

Provider Name (first and last)* | NPI No.* | Tax ID No.* | Phone No.*

Office Contact Name* | MMIS No. *(Medicaid/Child Health Plus Only)* | Fax No.*

Office Street Address* | City* | State* | Zip Code*

Section 3: Medication Requested *(*Required)*

Medication *(name, strength, and dosage form)** | Directions* | Quantity*

Does this require an expedited review?* ☐ Yes ☐ No | Is a generic substitution allowed?* ☐ Yes ☐ No

Is this to be administered by a Physician?* ☐ Yes ☐ No

If not obtained at a pharmacy for self-administration, complete 1 and 2 below:

1. Medication will be administered at: ☐ **MD office** ☐ **Hospital** ☐ **Infusion Center** ☐ **Home**

2. Medication will be supplied by *(check one)*:

- ☐ **MVP contracted Specialty Pharmacy**
- ☐ **Prescribing Physician's office, or if other 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)*

Name | NPI No. | Address

Section 3: Patient History

Case Specific Diagnosis/ICD10:

Is this 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 ☐ No

If ***Yes***, please provide details below.

Drug, Dose, and Frequency	*Approximate date range therapy began & stopped (write in range)*	*Outcome*

Please provide any additional clinical information relevant to review this request including but not limited to patient height, weight, allergies, comorbidities, lab results, specific medical needs. This information can also be provided as an attachment.

Section 4: Prescriber's Signature *(*Required)*

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 NYS False Claims Acts. Only the prescriber responsible for the treatment and evaluation of the Member, an authorized agent, the Member, or the Member's authorized representative may initiate a prior authorization or coverage determination.

*Prescriber's Signature** *Date**