MOLINA HEALTHCARE
Website: www.molinahealthcare.com

NYS Medicaid Prior Authorization Request Form For Prescriptions

Rationale for Exception Request or Prior Authorization - *All information must be complete and legible*

Patient Information

First Name:	Last Name:	MI:	☐ Male ☐ Female
Date of Birth: ___/___/____	Member ID:	Is patient transitioning from a facility? ☐ **Yes** ☐ **No** If yes, provide name of facility: _____	

Provider Information

First Name:	Last Name:		Address:	
NPI No:[1]	Phone No:	Fax No:	Office Contact:	Specialty:

Medication/Medical and Dispensing Information

Medication:	Strength:	Frequency:	Qty:	Refill(s):
Case Specific Diagnosis/ICD10:[2]	Route of Administration: ☐ Oral ☐ IM ☐ SC ☐ Transdermal ☐ IV ☐ Other For physician administered, will this provider be ordering & administering? ☐ **Yes** ☐ **No** If no, supply administering provider:			

Please check one of the following:

This is a new medication and/or new health plan for the patient. ☐ **If checked, *go to question 1***	This is continued therapy previously covered by the patient's current health plan. ☐ **If checked, approx. date initiated _____/_____. *Go to question 5***

1. Does the drug require a dose titration of either multiple strengths and/or multiple doses per day? ☐ **Yes** ☐ **No**
   If yes, provide titration schedule: _____
2. Is the drug being used for an FDA approved indication? ☐ **Yes** ☐ **No**
   2.(a) If the answer to 2 is **No**, is its use supported by Official Compendia (AHFS DI®, DRUGDEX ®)[3] ☐ **Yes** ☐ **No**
3. Has the patient experienced treatment failure with a preferred/formulary drug(s) or has the patient experienced an adverse reaction with a preferred/formulary drug(s) in the therapeutic class? If yes, complete the following: ☐ **Yes** ☐ **No**

Drug and Dose	Route	Frequency	Approx. date range therapy began & stopped	Outcome
			_____/_____ _____/_____	
			_____/_____ _____/_____	

4. Is there documented history of successful therapeutic control with a non-preferred/non-formulary drug and transition to a preferred/formulary drug is medically contraindicated? If yes, explain: ☐ **Yes** ☐ **No**

5. Is this a change in dosage/day for the above medication? ☐ **Yes** ☐ **No**
6. Does the request require an expedited review?* **Rationale**_____ ☐ **Yes** ☐ **No**
7. Attach relevant lab results, tests and diagnostic studies performed that support use of therapy. **Check if attached** ☐

Required clinical information: Please provide all relevant clinical information in the box below to support a medical necessity to determine coverage. Refer to health plan coverage requirements for the requested medication (see link above).
☐ Please check here if documentation is attached.

I attest that this information is accurate and true, and that the supporting documentation is available for review upon request of said plan, the NYSDOH or CMS. I understand that any person who knowingly makes or causes to be made a false record or statement that is material to a Medicaid MC claim may be subject to civil penalties and treble damages under both federal and NYS False Claims Acts.

Prescriber's Signature _____ Date ___/___/_____

Instructional Information for Prior Authorization

Upon our review of all required information, you will be contacted by the health plan.

When providing required clinical information, the following elements should be considered within the rationale to support your medical necessity request:

- *Height/Weight*
- *Compound ingredients*
- *Specific dosage form consideration*
- *Drug or Other Related Allergies*

Please consider providing the following information as applicable & when available:

- *Healthcare Common Procedure Coding System (HCPCS)* [4]
- *Transition of Care Hospital and/or Residential Treatment Facilities Information (contact, phone number, length of stay)*
- *Life Situations Information such as foster care transition, homelessness, poly-substance abuse and history of poor medication adherence*
- *Patient information (address, phone number)*
- *Provider information (direct electronic contact information: e-mail, etc.)*

*An expedited review will be considered when a condition exists that places the health or safety of the person afflicted with such condition or other person (s) in serious jeopardy. Expedited review is defined as determination and notification made no greater than three (3) business days from date of request. An emergency 72 hour supply (5 day supply for medications to treat substance use disorders) may be requested by the provider in cases where an emergency condition exists as defined above. https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf

This form must be signed by the prescriber but can also be completed by the prescriber or his/her authorized agent. *An authorized agent is an employee of the prescribing practitioner and has access to the patient's medical records (i.e. nurse, medical assistant*). The completed fax form and any supporting documents must be faxed to the proper health plan.

Helpful Definitions

[1] **NPI:** A national provider identifier (NPI) is a unique ten-digit identification number required by HIPAA for all health care providers in the United States. https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/index.html

[2] **ICD-10:** The International Classification of Diseases (ICD) is designed to promote international comparability in the collection, processing, classification, and presentation of mortality statistics http://www.cdc.gov/nchs/icd.htm

[3] **AHFS Drug Information® (AHFS DI®)** provides evidence-based evaluation of pertinent clinical data concerning drugs, with a focus on assessing the advantages and disadvantages of various therapies, including interpretation of various claims of drug efficacy. http://www.ahfsdruginformation.com/ **DRUGDEX ®** System within the Micomedex product which provides peer-reviewed, evidence-based drug information including investigational & non prescription drugs. http://www.micromedex.com/

[4] **The HCPCS** is divided into two principal subsystems, referred to as level I and level II of the HCPCS:

- Level I of the HCPCS is comprised of CPT (Current Procedural Terminology), a numeric coding system maintained by the American Medical Association (AMA). The CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals.

- Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office.