New Mexico Uniform Prior Authorization Form

To file electronically, send to: n/a (will be available by 1/1/2021)                           To file via facsimile, send to: 1-877-235-9905

To contact the coverage review team please call the number on the back of the member’s ID card.

[1] Priority and Frequency
a. Standard [] Services scheduled for this date:  b. Urgent/Expedited [] Provider certifies that applying the standard review timeline may seriously jeopardize the life or health of the enrollee.

c. Frequency Initial [ ] Extension [ ] Previous Authorization #: [ ]

[2] Enrollee Information
a. Enrollee name: [ ]

b. Enrollee date of birth: [ ]
c. Subscriber/Member ID #: [ ]
d. Enrollee street address: [ ]
e. City: [ ]
f. State: [ ]
g. Zip code: [ ]

[3] Provider Information: Ordering Provider [] Rendering Provider [] Both [] Please note: processing delays may occur if rendering provider does not have appropriate documentation of medical necessity. Ordering provider may need to initiate prior authorization.
a. Provider name: [ ]
b. Provider type/specialty: [ ]
c. Administrative contact: [ ]
d. NPI #: [ ]
e. DEA# if applicable: [ ]
f. Clinic/facility name: [ ]
g. Clinic/pharmacy/facility street address: [ ]
h. City, State, Zip code: [ ]
i. Phone number and ext.: [ ]
j. Facsimile/Email: [ ]

[4] Requested medical or behavioral health course of treatment/procedure/device information (skip to Section 8 if drug requested)
a. Service description: [ ]
b. Setting/CMS POS Code: Outpatient [] Inpatient [] Home [] Office [] Other* []
c. *Please specify if other:

a. Latest ICD-10 Code: [ ]
b. HCPCS/CPT/CDT Code: [ ]
c. Medical Reason: [ ]

d. Frequency/Quantity/Repetition Request
a. Does this service involve multiple treatments? Yes [] No [] If "No," skip to Section 7.
b. Type of service: [ ]
c. Name of therapy/agency: [ ]
d. Units/Volume/Visits requested: [ ]
e. Frequency/length of time needed: [ ]

[8] Prescription Drug
a. Diagnosis name and code: [ ]
b. Patient Height (if required): [ ]
c. Patient Weight (if required): [ ]
d. Route of administration: Oral/SL [] Topical [] Injection [] IV [] Other* []
*Explain if "Other:"
e. Administered: Doctor’s office [] Dialysis Center [] Home Health/Hospice [] By patient []
<table>
<thead>
<tr>
<th>f. Medication Requested</th>
<th>g. Strength (include both loading and maintenance dosage)</th>
<th>h. Dosing Schedule (including length of therapy)</th>
<th>i. Quantity per month or Quantity Limits</th>
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j. Is the patient currently treated with the requested medication[s]? Yes* [ ] No [ ]

*If "Yes," when was the treatment with the requested medication started? Date:

k. Anticipated medication start date (MM/DD/YY):

l. General prior authorization request. Explain the clinical reason(s) for the requested medications, including an explanation for selecting these medications over alternatives:

l. Rationale for drug formulary or step therapy exception request:

- **Alternate drug(s) contraindicated or previously tried, but with adverse outcome,** e.g., toxicity, allergy, or therapeutic failure, Specify below:
  1. Drug(s) contraindicated or tried;
  2. adverse outcome for each;
  3. if therapeutic failure, length of therapy on each drug(s).

- **Patient is stable on current drug(s),** high risk of significant adverse clinical outcome with medication change. Specify anticipated significant adverse clinical outcome below.

- **Medical need for different dosage and/or higher dosage,** Specify below:
  1. Dosage(s) tried;
  2. explain medical reason.

- **Request for formulary exception,** Specify below:
  1. Formulary or preferred drugs contraindicated or tried and failed, or tried and not as effective as requested drug;
  2. if therapeutic failure, length of therapy on each drug and adverse outcome;
  3. if not as effective, length of therapy on each drug and outcome.

- **Other** (explain below)

**Required explanation(s):**

m. List any other medications patient will use in combination with requested medication:

n. List any known drug allergies:

[8] Previous services/therapy (including drug, dose, duration, and reason for discontinuing each previous service/therapy)

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<th>a.</th>
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<td>b.</td>
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<td>c.</td>
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[9] Attestation

I hereby certify and attest that all information provided as part of this prior authorization request is true and accurate.

Requester Signature______________________________ Date________________

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DO NOT WRITE BELOW THIS LINE. FIELDS TO BE COMPLETED BY PLAN.

Authorization#____________________ Contact name__________________________

Contact’s credentials/designation________________________________________