# New Mexico Uniform Prior Authorization Form

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| **To file electronically, send to:** [INSERT WEB ADDRESS HERE] | **To file via facsimile, send to:** [INSERT FAX NUMBER HERE] |

To contact the coverage review team for [INSERT PLAN NAME], please call [INSERT PHONE NUMBER] between the hours of [INSERT HOURS]. For after-hours review, please contact [INSERT PHONE NUMBER].

**[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: Iris Tito | b. Enrollee date of birth: 15/03/1997 | c. Subscriber/Member ID #: ABC5555555 |
| d. Enrollee street address: 610 Homestuck Ave | | |
| e. City: Murietta | f. State: CA | g. Zip code: 95771 Patient Email: IrisT@gmail.com |

**[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: Mantis Tobaggan | b. Provider type/specialty: Tonsilology | c. Administrative contact: |
| d. NPI #: | | e. DEA # if applicable: |
| f. Clinic/facility name: Younglings Clinic | | g. Clinic/pharmacy/facility street address: |
| h. City, State, Zip code 87987 | i. Phone number and ext.: 777-777-7777 | j. Facsimile/Email: mantis.tobaggan@gmail.com |

**[4] Requested medical or behavioral health course of treatment/procedure/device information (skip to Section 8 if drug requested)**

a. Service description: Take them tonsils out

b. Setting/CMS POS Code Outpatient [X] Inpatient [ ] Home [ ] Office [ ] Other* [ ]

c. *Please specify if other:

**[5] HCPCS/CPT/CDT/ICD-10 CODES**

| a. Latest ICD-10 Code | b. HCPCS/CPT/CDT Code | c. Medical Reason |
|---|---|---|
| I15 | | |
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**[6] Frequency/Quantity/Repetition Request**

a. Does this service involve multiple treatments? Yes [ ] No [ ] If "No," skip to Section 7.

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|---|---|
| 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 [ ]

| f. Medication Requested | g. Strength (include both loading and maintenance dosage) | h. Dosing Schedule (including length of therapy) | i. Quantity per month or Quantity Limits |
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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)** | |
|---|---|
| a. | Date Discontinued: |
| b. | Date Discontinued: |
| c. | Date Discontinued: |

**[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 _____