

Prior Authorization Review Request Form

Please complete all of the sections below for this request to be considered
 Fax completed form to: **(505) 923-5540 or 1-800-724-6953**
 For help with completing this Form, please call (505) 923-5757, press 3 or 1-888-923-5757, press 3
ONE DRUG PER FORM PLEASE

SECTION 1: MEMBER INFORMATION

ID Number: _____ Social Security Number: _____ Name: _____ Date of Birth: _____	Drug: _____ Dosing: _____ Strength: _____ Diagnosis: _____ Length of Therapy: _____
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SECTION 2: PRACTITIONER INFORMATION

Requesting Practitioner: _____ Practitioner Signature: _____ Phone Number: _____	Specialty: _____ Requestor: _____ Fax Number: _____
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SECTION 3: REQUEST INFORMATION

Please complete items 1 and 2. Incomplete requests will result in a denial.

1. In order for this request to be considered, the member must meet **one** of the following conditions:
 Member has tried and failed all preferred alternatives. Please list alternative(s) tried and reason for failure below.
 Member has a documented medical reason or allergy to a preferred medication.

2. Please provide a detailed explanation as to why this member requires a Prior Authorization for a non-preferred medication. Or, provide information **including chart notes and lab data** that support your clinical justification. Attach extra sheets as necessary.

PHARMACY SERVICES DEPARTMENT USE ONLY

<input type="checkbox"/> ASO _____	<input type="checkbox"/> COMM _____	<input type="checkbox"/> PIC _____	<input type="checkbox"/> MCAID _____	<input type="checkbox"/> SRCARE _____
GROUP _____				
Prior Authorization Number:	<input type="checkbox"/> Approved	<input type="checkbox"/> Denied		
Pharmacist Review:			Date:	
Medical Director:			Date:	
Comments:				

CONFIDENTIAL: PROTECTED HEALTH INFORMATION ENCLOSED Protected Health Information (PHI) is personal and sensitive information related to a person's health care. It is being delivered to you after appropriate authorization from the patient/member or under circumstances that don't require patient authorization. You, the recipient, are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure without additional patient/member consent or as permitted by law is prohibited. Unauthorized re-disclosure of failure to maintain confidentiality could subject you to penalties described in federal and state law.