Prior Authorization Request
For Prescriptions

Prescription requests may require prior authorization for service(s) to be rendered.

Instructions for Completing this Request

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

Information provided on this form is protected health information, and subject to all privacy and security regulations under HIPAA.

Section 1: MVP Member Information

*(*Required Information)*

Member Name*	Date of Birth*	MVP Member ID No.*	Vermont Resident?* ☐ Yes ☐ No

Section 2: Requesting Provider Information

*(*Required Information)*

Requesting Provider Name*	NPI No.*	Tax ID No.*	Phone No.*

Office Contact Name*	MMIS No. *(Medicaid/CHPlus Only)*	Fax No.*

Office Street Address*	City*	State*	Zip Code*

Section 3: Medication Requested

*(*Required Information)*

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 questions 1 and 2 below.

1. Where will the medication will be administered? ☐ **MD Office** ☐ **Hospital** ☐ **Infusion Center** ☐ **Home**
2. How will the medication be supplied?

☐ **MVP contracted Specialty Pharmacy** ☐ **Home Care Company** *(provide Name, NPI No. ,and Address below)*

☐ **Prescribing Physician's office, or other MD office** *(provide Name, NPI No. ,and Address below)*

☐ **Outpatient Hospital/Infusion Center** *(provide Name, NPI No. ,and Address below)*

Name	NPI No.	Address

Section 4: Patient History

*(*Required Information)*

Case Specific Diagnosis/ICD-10 Codes*

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 *(provide details below)* ☐ No

Drug, Dose, and Frequency	*Approximate date range therapy began and stopped*	*Outcome*

MVP Member Name *MVP Member ID No.*

*(**Section 4** continued)*

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 5: Prescriber's Attestation

*(*Required Information)*

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 New York State 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**