NYRx, the Medicaid Pharmacy Program

Prescription Prior Authorization Request Form

Fax this form to 1-800-268-2990   For questions call 877-309-9493

Requests are responded to within 24 hours

Attention: Preferred products, used in accordance with FDA labeling, may not require Prior Authorization. For a preferred product, see NYRx Preferred Drug List at http://newyork.fhsc.com.

PATIENT INFORMATION

Patient Last Name: _____

Patient First Name: _____   Middle Initial: _____

Patient Medicaid ID: _____   Date of Birth: _____

Sex: ☐ Male   ☐ Female   ☐ X   *Is patient transitioning from a facility? ☐ Yes   ☐ No

If **Yes**, provide Facility Name*: _____

PROVIDER INFORMATION

Provider Last Name: _____

Provider First Name: _____

Provider NPI Number[1]: _____   Specialty: _____

Provider Street Address: _____

City: _____   State: _____   Zip: _____

Provider Phone: _____   Provider Fax: _____

Office Contact: _____

MEDICATION AND DISPENSING INFORMATION

Drug Name: _____   Drug Strength: _____

Drug Form: _____   Dosing Frequency: _____

Quantity: _____   Number of Refills: _____

Diagnosis: _____   ICD-10 Code[2]: _____

Route of Administration (check one):

☐ Oral   ☐ IM   ☐ SC   ☐ Transdermal   ☐ IV

☐ Other: _____

For physician-administered medication, will this provider be ordering and administering?

☐ Yes   ☐ No   **If No**, list administering provider: _____

Please check one of the following:

☐ New medication and/or new health plan   ☐ Continued therapy previously covered

If you checked **Continued**, list approximated date therapy initiated: _____

If new drug and/or Medicaid member, **go to question 1**. If continued therapy, **go to question 5**.

Patient's Name: _____

MEDICATION AND DISPENSING INFORMATION *(CONTINUED)*

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

   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 or has the patient experienced an adverse reaction with a preferred/formulary drug in the therapeutic class?

   ☐ Yes   ☐ No

   If Yes, detail the treatment failure or adverse reaction: _____

   a. Drug and Dose: _____

   Route: _____   Frequency: _____

   Approximate date therapy began, stopped: _____ to _____

   Outcome: _____

   b. Drug and Dose: _____

   Route: _____   Frequency: _____

   Approximate date therapy began, stopped: _____ to _____

   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?

   ☐ Yes   ☐ No   **If Yes**, explain: _____

5. Is this a change in dosage/day for the above medication?

   ☐ Yes   ☐ No

6. Does the request require an expedited review?

   ☐ Yes   ☐ No

7. Attach relevant lab results, tests and diagnostic studies performed that support use of therapy.

   ☐ Check if documentation attached.

Required clinical information: Please provide all relevant clinical information to support a medical necessity review to determine coverage. Refer to NYRx coverage requirements for the requested medication at http://newyork.fhsc.com.

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

Instructional Information for Prior Authorization

Upon review of all required information, you will be contacted by Magellan Rx Management, LLC.

- 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 and 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 emergency 72-hour supply may be requested by the provider in cases where an emergency condition exists.

This form can 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 Micromedex product which provides peer-reviewed, evidence-based drug information including investigational & nonprescription 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.