

## For Behavioral Providers

**To file electronically, providers in New Mexico must register for access to the online prior authorization tool:**

To initiate registration, send an email to

- Provider or facility name
- Mailing address
- Email address
- Contact name
- Contact telephone number

**To file via facsimile send to:**  
866.217.6837

and include the following information:

# New Mexico Uniform Prior Authorization Form

Priority and Frequency		
a. <b>Standard</b> <input type="checkbox"/> Services scheduled for this date: _____		b. <b>Urgent/Expedited</b> <input type="checkbox"/> Provider certifies that applying the standard review timeline may seriously jeopardize the life or health of the enrollee.
c. <b>Frequency</b> Initial <input type="checkbox"/> Extension <input type="checkbox"/> 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 <input type="checkbox"/> Rendering Provider <input type="checkbox"/> Both <input type="checkbox"/>		
<i>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.</i>		
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 <input type="checkbox"/> Inpatient <input type="checkbox"/> Home <input type="checkbox"/> Office <input type="checkbox"/> Other* <input type="checkbox"/>		
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
[6] Frequency/Quantity/Repetition Request		
a. Does this service involve multiple treatments? Yes <input type="checkbox"/> No <input type="checkbox"/> 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:

**[7] 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

j. Is the patient currently treated with the requested medication(s)? Yes\*  No 

\*If "Yes", when was the treatment with the requested medication started? \_\_\_\_\_

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:

m. 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):**

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

o. 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 \_\_\_\_\_

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

Authorization # \_\_\_\_\_ Contact name \_\_\_\_\_

Contact's credentials/designation \_\_\_\_\_