



Presbyterian Health Plan, Inc.
 Presbyterian Insurance Company, Inc.

New Mexico Uniform Prior Authorization Form

To reach the Coverage Review team for Presbyterian Health Plan, please call between the hours of 8 a.m. – 5 p.m. **For after-hours review**, please call (505) 923-5757 or 1-888-923-5757, option 9 followed by option 3 for pharmacy, option 4 for medical prior authorization, and option 5 for behavioral health.

Department	Fax #	Phone #	To file electronically, go to:
Physical Health Services	(505) 843-3047	(505) 923-5757 or 1-888-923-5757, option 4 followed by 1	www.phs.org/providers/authorizations
Pharmacy Services	(505) 923-5540 or 1-800-724-6953	(505) 923-5757, option 3	
Medical Inpatient UM	(505) 843-3107	(505) 923-5757 or 1-888-923-5757, option 4 followed by 1	
Home Health Care	(505) 559-1150		
UNM Prior Authorization	(505) 843-3108		
Behavioral Health	Turquoise Care (505) 843-3019	(505) 923-5757 or 1-888-923-5757, option 4 followed by 2	Turquoise Care: nmturquoise@magellanhealth.com
	Medicare/Comm 1-888-656-4967	1-800-424-4661	Medicare/Commercial: www.magellanhealth.com/provider
Evolent Specialty Services	Musculoskeletal Surgery - Spine 1-800-784-6864	1-866-236-8717	https://www1.radmd.com
	Oncology Office Administered Rx Office admin infused / injectable chemotherapy 1-213-596-3783	1-866-500-7729 option 1	https://carepro.evolent.com/
	Radiation Oncology 1-714-494-8366	1-866-500-7729 option 2	https://carepro.evolent.com/
Stanson Health (Advanced Imaging)	1-646-502-5041	1-888-487-0733	https://php.careportal.com/

[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:

b. Enrollee date of birth:

c. Subscriber/Member ID #:

d. Enrollee street address:

e. City:	f. State:	g. ZIP code:	
[3] Provider Information: <input type="checkbox"/> Ordering Provider <input type="checkbox"/> Rendering Provider <input type="checkbox"/> 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:	b. Provider type/specialty:	c. Administrative contact:	
d. NPI #:	e. DEA # (if applicable):		
f. TIN:			
g. Clinic/facility name:		h. Clinic/pharmacy/facility street address:	
i. City, State, ZIP code	j. Phone number and extension:	k. Facsimile/Email:	
[4] Requested medical or behavioral health course of treatment/procedure/device information (skip to Section 7 if drug requested)			
a. Service description:			
b. Setting/CMS POS Code: <input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient <input type="checkbox"/> Home <input type="checkbox"/> Office <input type="checkbox"/> 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	
[6] Frequency/Quantity/Repetition Request			
a. Does this service involve multiple treatments? <input type="checkbox"/> Yes <input type="checkbox"/> No 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: <input type="checkbox"/> Oral/SL <input type="checkbox"/> Topical <input type="checkbox"/> Injection <input type="checkbox"/> IV <input type="checkbox"/> Other*			
* Explain if "Other:"			
e. Administered: <input type="checkbox"/> Doctor's Office <input type="checkbox"/> Dialysis Center <input type="checkbox"/> Home Health/Hospice <input type="checkbox"/> 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]? <input type="checkbox"/> Yes* <input type="checkbox"/> 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: <ul style="list-style-type: none"> <input type="checkbox"/> 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). <input type="checkbox"/> Patient is stable on current drug(s), high risk of significant adverse clinical outcome with medication change. Specify anticipated significant adverse clinical outcome below. <input type="checkbox"/> Medical need for different dosage and/or higher dosage, specify below: (1) Dosage(s) tried; (2) explain medical reason. <input type="checkbox"/> 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. <input type="checkbox"/> 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 _____	
DO NOT WRITE BELOW THIS LINE. FIELDS TO BE COMPLETED BY PLAN.	
Authorization # _____ Contact name _____	
Contact's credentials/designation _____	

Such services are funded in part with the State of New Mexico.

Based on a Model of Care review, Presbyterian Dual Plus (HMO D-SNP) has been approved by the National Committee for Quality Assurance (NCQA) to operate a Special Needs Plan (SNP) through 2028.

Learn more about Presbyterian's Nondiscrimination Notice and Interpreter Services at <https://www.phs.org/nondiscrimination>.