



# Step by Step:

How to Submit a  
Prior Authorization Online

# Attention:

Prescribers may submit a prior authorization request for a formulary medication **or** request an exception once a member has tried and failed formulary medications.

# 1. Enter your **myPRES** user ID and password.

**PRESBYTERIAN** Login



Signing into myPres makes filling out the request form much easier as some of the information will be auto-filled from your account.

However if you want, you may continue as a guest user. Guest users can only submit a **limited number of requests per day.**

**CONTINUE AS GUEST** >

### myPres Login

**User ID**

**Password**

By signing in, you agree to our [Terms of Use](#) and [Privacy Statement](#)

**LOGIN** >

Don't have an account? [Register for myPRES](#)

## 2. Select the “**Standard**” request type if a response can be returned with 72 hours.

**PRESBYTERIAN** Logged in as JEGBERT1 | [Logout](#)

### Provider Pharmacy Prior Authorization Form (For Exception Requests)

This form is for providers who want to submit a Pharmacy Prior Authorization Form and request an exception to cover their drug. To complete this form now, you will need to provide the name of the medication, dose and the quantity you are requesting, the reason for your exception request, your contact information and contact information for the prescriber and pharmacy. You will also have the option to attach documents, if needed. It may take you about 15 minutes to submit one request form.

[Click here to read more about Exception Requests.](#)

**Request Type \***

**Standard**

Expedited/Urgent

**DISCLAIMER FOR STANDARD Request for Drug Prior Authorization (or Coverage Determination)** - For a “Standard Request”, the decision is typically made within a 72 hour timeframe using the information you provide. By selecting a “Standard Request”, you agree

The information provided with this request is complete, accurate and true to the best of your knowledge. (The health plan can determine most standard requests within one business day when the information provided is complete.)

**Disclaimer \***

I Accept

**NEXT** >

\*Required Information

### 3. Select “**Expedited/Urgent**” request type if a response must be returned within 24 hours.

**PRESBYTERIAN** Logged in as JEGBERT1 | Logout

#### Provider Pharmacy Prior Authorization Form (For Exception Requests)

This form is for providers who want to submit a Pharmacy Prior Authorization Form and request an exception to cover their drug. To complete this form now, you will need to provide the name of the medication, dose and the quantity you are requesting, the reason for your exception request, your contact information and contact information for the prescriber and pharmacy. You will also have the option to attach documents, if needed. It may take you about 15 minutes to submit one request form.

[Click here to read more about Exception Requests.](#)

**Request Type \***

Standard

**Expedited/Urgent**

**DISCLAIMER FOR EXPEDITED/URGENT Request for Drug Prior Authorization (or Coverage Determination)** – For an “Expedited or Urgent Request”, the decision is typically made within a 24 hour timeframe using the information you provide. By selecting an “Expedited/Urgent Request” , you agree

- 1) the information provided with this request is complete, accurate and true to the best of your knowledge and
- 2) the health of the member could be seriously harmed by waiting up to 72 hours for a Standard request and decision from the health plan.

**Disclaimer \***

I Accept

**NEXT** >

\*Required Information

## 4. Enter “Member Information.”

Provider Pharmacy Prior Authorization Form (For Exception Requests)

Member Information    Prescriber Information    Requested Medication    Pharmacy/Facility Information    Upload Documents

### Member Information

Insurer \*    Date

PRESBYTERIAN    03/05/2018

Member # \*    Group #

10110120200    Q    TESTBASE

Name of Insured

John Doe

Patient Last Name \*    Patient First Name \*    Patient Middle Initial

Doe    John   

Patient Date of Birth \*    Patient Address

05/08/1976    1000 Meadow Lane

City    State    Zip Code

ALBUQUERQUE    NM    87111

Email

Primary Phone Number    Mobile Phone Number    Work Phone Number

(505) 222-2222    (505) 222-2244    (XXX) XXX-XXXX

Patient Height    Patient Weight    Patient Gender

5 feet, 11 inches    160 pounds     Male

Female

\*Required Information

## 5. Enter “Prescriber” information.

Provider Pharmacy Prior Authorization Form (For Exception Requests)

Member Information   Prescriber Information   Requested Medication   Pharmacy/Facility Information   Upload Documents

### Prescriber Information

NPI # \*  
10103727

DEA #

Specialty  
PCP

Group Practice or Organization  
PMG

Contact Name  
JOHN EGBERT

Prescriber Name \*  
John Egbert

Prescriber Address \*  
2000 Harper Dr. NE

City \*  
Albuquerque

State \*  
NM

Zip Code \*  
87111

Prescriber Phone Number \*  
(505) 265-4747 ext. XXXXX

Prescriber Fax Number \*  
(505) 265-4744

PREVIOUS   NEXT

\*Required Information

## 6. Enter “Requested Medication.”

Provider Pharmacy Prior Authorization Form (For Exception Requests)

Member Information    Prescriber Information    **Requested Medication**    Pharmacy/Facility Information    Upload Documents

**Requested Medication**

Provide sufficient information to identify the medication, the dosage and the anticipated duration of treatment.

Diagnoses \*

M17 x ADD ICD-10 CODES

Drug or Item \*    Dosage \*

Celecoxib 200mg    1 PO QD

Reason for Request \*

Patient has tried all alternatives. This medication works best for his knee pain.

Quantity \*    Days Supply \*    Number of Refills \*

90    90    3

Start Date    End Date

03/05/2018    03/05/2019

PREVIOUS    NEXT

\*Required Information

## 7. Enter “Pharmacy/Facility” information.

Provider Pharmacy Prior Authorization Form (For Exception Requests)

Member Information    Prescriber Information    Requested Medication    **Pharmacy/Facility Information**    Upload Documents

### Pharmacy/Facility Information

While not essential to complete this section, it is often efficient for the patient and all others to allow the insurer to work directly with the pharmacy or other facility to arrange for the dispensing. Sufficient information is necessary to assure the authorization is communicated to the correct dispensing pharmacy or other entity. Many Pharmacies have the same name, so additional information is always required.

Pharmacy Name <input type="text" value="Walgreens"/>	Pharmacy Address * <input type="text" value="700 E 21st Street Clovis, NM 88101"/>
Pharmacy Phone Number <input type="text" value="(575) 762-3851"/>	Pharmacy Fax Number * <input type="text" value="(575) 762-5698"/>

[< PREVIOUS](#) [NEXT >](#)

\*Required Information

## 8. “Upload” supporting documents.

Provider Pharmacy Prior Authorization Form (For Exception Requests)

Member Information    Prescriber Information    Requested Medication    Pharmacy/Facility Information    **Upload Documents**

### Upload Documents

Please upload any supporting documentation you may have.

**A maximum of 10MB/file, 15MB total may be uploaded.** If you have files exceeding these limits, please contact us by phone or fax.

**BROWSE FILES**  **OR** Drag & Drop your files here

**PREVIOUS** **NEXT**

\*Required Information

9. Type in your first and last name, confirm and acknowledge, and select “**Yes**” if you want to view your form. Then submit form.

Provider Pharmacy Prior Authorization Form (For Exception Requests)

Member Information    Prescriber Information    Requested Medication    Pharmacy/Facility Information    Upload Documents

Electronic Signature (First and Last Name) \*

John Egbert

Checking this box constitutes a legal signature confirming that you acknowledge and warrant the truthfulness of the information provided in this document. \*

I Accept

Receive confirmation number in email?

Yes

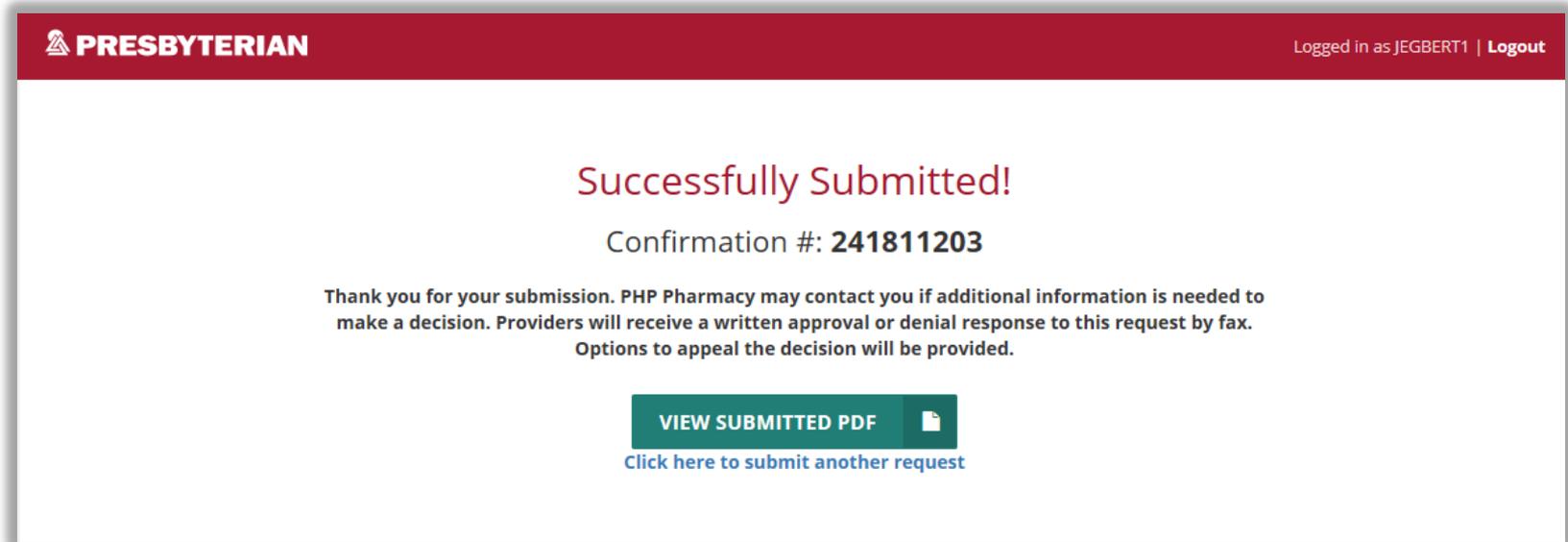
Would you like to view your submitted form as a PDF?

Yes

[< PREVIOUS](#)    [SUBMIT FORM >](#)

\*Required Information

# 10. Receive Confirmation.



The screenshot shows a web interface with a dark red header. On the left, the Presbyterian logo and name are displayed. On the right, the user is logged in as 'JEGBERT1' with a 'Logout' link. The main content area is white and features a large red heading 'Successfully Submitted!'. Below this, the confirmation number '241811203' is shown. A paragraph of text explains that the submission is complete and that a decision will be provided by fax, with appeal options available. At the bottom, there is a green button labeled 'VIEW SUBMITTED PDF' with a document icon, and a blue link to 'Click here to submit another request'.

**PRESBYTERIAN** Logged in as JEGBERT1 | [Logout](#)

## Successfully Submitted!

Confirmation #: **241811203**

Thank you for your submission. PHP Pharmacy may contact you if additional information is needed to make a decision. Providers will receive a written approval or denial response to this request by fax. Options to appeal the decision will be provided.

[VIEW SUBMITTED PDF](#) 

[Click here to submit another request](#)

# EXAMPLE



## Provider Pharmacy Prior Authorization Form

Request Type	Confirmation #	Insurer	Timestamp
Standard	241811203	PRESBYTERIAN	03/05/2018 09:23 am

Member Information	Group #	Member #	Name of Insured	
	TESTBASE	10110120200	John Doe	
Patient Last Name	First	Initial	Date of Birth	
Doe	John		05/08/1976	
Patient Address		City	State	Zip Code
1000 Meadow Lane		ALBUQUERQUE	NM	87111
Primary Phone #	Mobile Phone #	Work Phone #	Email	
(505) 222-2222	(505) 222-2244			
Patient Height		Patient Weight	Patient Gender	
5 feet, 11 inches		160 pounds	Male	

Prescriber Information	NPI #	DEA #		
	10103727			
Specialty		Group Practice or Organization		
PCP		PMG		
Prescriber Name		Contact Name		
John Egbert		JOHN EGBERT		
Prescriber Address		City	State	Zip Code
2000 Harper Dr. NE		Albuquerque	NM	87111
Prescriber Phone #		Prescriber Fax #		
(505) 265-4747 ext. XXXXX		(505) 265-4744		

Requested Medication	Drug or Item	Dosage
	Celecoxib 200mg	1 PO QD
Diagnoses		
M17		
Reason for Request		
Patient has tried all alternatives. This medication works best for his knee pain.		
Quantity	Days Supply	Number of Refills
90	90	3

Pharmacy/Facility Information	Pharmacy Name		
	Walgreens		
Pharmacy Address		Pharmacy Phone #	Pharmacy Fax #
700 E 21st Street Clovis, NM 88101		(575) 762-3851	(575) 762-5698

Provided Documents
none