MEDICATION PRIOR AUTHORIZATION FORM

In accordance with SB282, Effective 9/21/2017 Health Plan of San Joaquin/Mountain Valley Health Plan (HPSJ/MVHP) will only accept the DMHC mandated statewide prior authorization form (Form 61-211, revised 12/16) which can be found on the next page.

Requests made on the old HPSJ/MVHP Prior Authorization Form or any other form (including the Medi-Cal TAR request form) will be denied until it is resubmitted on the required form (Form 61-211, revised 12/16).

The form may be found at **https://www.hpsj.com/forms-documents/** under Pharmacy Tools & Resources.

HPSJ/MVHP Medication Prior Authorization Resources:

Number	Resource
(209) 942-6303 (phone)	**Eligibility Verification (IVR)** *Use Medi-Cal number (first 9 digits including letter) or S.S.N. to obtain HPSJ/MVHP number*
(209) 762-4704 (fax)	**Fax number for HPSJ/MVHP UM Department** *Fax prior authorization requests and supporting documentation to this number*
(209) 942-6340 (phone)	**Provider Services** *General questions or concerns*

Instructions:

1. Complete the attached Prior Authorization Request Form. All fields must be filled out.
2. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization request.
3. Submit the completed form with supporting documentation to HPSJ/MVHP at (209) 762-4704

Tips for submitting successful prior authorization requests:

- ☒ Fill out all fields on the PA form. BOTH sides of this two page form must be submitted.
- ☒ Submit all relevant clinic notes, consultations, and lab values. The better picture we have of the clinical situation, the better the chances for approval.
- ☒ Use formulary alternatives (available using the Formulary Lookup Tool at www.hpsj-mvhp.org)before requesting prior authorization. An adequate trial of formulary alternatives (including dose and duration) is required before concluding treatment failure.
- ☒ For other medications tried, submit dates of therapy and results from those trials. Also attach clinic notes and/or prescription history documenting use of alternative agents.

Identify the Filling Pharmacy:

Please identify the filling pharmacy somewhere on the form. This is important in order for HPSJ/MVHP to notify the pharmacy as soon as possible after a decision has been made. If the pharmacy is filling out the form, please use pharmacy stamp.

Thank you in advance for your cooperation with this state mandated requirement.

Health Plan of San Joaquin | Mountain Valley Health Plan

PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Plan/Medical Group Name:_____ Plan/Medical Group Phone#: _____
Plan/Medical Group Fax #: _____ Non-Urgent ☐ Exigent Circumstances ☐

Patient Information					
First Name:	Last Name:		MI:	Phone Number:	
Address:	City:		State:	Zip Code:	
Date of Birth:	☐ Male ☐ Female	Circle unit of measure Height (in/cm):_____Weight (lb/kg):_____		Allergies:	
Patient's Authorized Representative (if applicable):			Authorized Representative Phone Number:		
Insurance Information					
Primary Insurance Name:	Patient ID Number:	Secondary Insurance Name:		Patient ID Number:	
Prescriber Information					
First Name:	Last Name:		Specialty:		
Address:	City:		State:	Zip Code:	
Requestor (if different than prescriber):		Office Contact Person:			
NPI Number (individual):		Phone Number:			
DEA Number (if required):	Fax Number (in HIPAA compliant area):		Email Address:		
Medication / Medical and Dispensing Information					
Medication Name:					
☐ New Therapy ☐ Renewal ☐ Step Therapy Exception Request If Renewal: Date Therapy Initiated: Duration of Therapy (specific dates):					
How did the patient receive the medication? ☐ Paid under Insurance Name:_____Prior Auth Number (*If known*): _____ ☐ Other (*explain*):					
Dose/Strength:	Frequency:	Length of Therapy/#Refills:	Quantity:		
Administration: ☐ Oral/Sl ☐ Topical ☐ Injection ☐ IV ☐ Other:					
Administration Location: ☐ Physician's Office ☐ Ambulatory Infusion Center	☐ Patient's Home ☐ Home Care Agency ☐ Outpatient Hospital Ca	☐ Long Term Care ☐ Other (*explain*):_____			

Health Plan of San Joaquin | Mountain Valley Health Plan

PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Patient Name:	**ID #:**

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization or step therapy exception request.

1. Has the patient tried any other medications for this condition? ☐ YES (*if yes, complete below*) ☐ NO

Medication/Therapy *(Specify Drug Name and Dosage)*	**Duration of Therapy** *(Specify Dates)*	**Response/Reason for Failure/Allergy**

2. List Diagnoses:	**ICD-10:**

3. Required clinical information - Please provide all relevant clinical information to support a prior authorization or step therapy exception request review.

Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if patient has any contraindications for the health plan/insurer preferred drug. Lab results with dates must be provided if needed to establish diagnosis, or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage, including information related to exigent circumstances, or required under state and federal laws. ☐ **Attachments**

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

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Plan/Insurer Use Only:

Date/Time Request Received by Plan/Insurer: _____ Date/Time of Decision: _____

Fax Number: _____

☐ Approved ☐ Denied Comments/Information Requested: _____

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