NEW YORK STATE OF OPPORTUNITY. Department of Health

Website: https://newyork.fhsc.com/providers/PDP_about.asp

NYS Medicaid Prior Authorization Request Form For Prescriptions

Rationale for Exception Request or Prior Authorization – *All information must be complete and legible*

Patient Information

First Name:	Last Name:	MI:	☐ Male ☐ Female
Date of Birth: ___/___/____	Member ID:	Is patient transitioning from a facility? ☐ **Yes** ☐ **No** If yes, provide name of facility: _____	

Provider Information

First Name:	Last Name:		Address:	
NPI No:[1]	Phone No:	Fax No:	Office Contact:	Specialty:

Medication/Medical and Dispensing Information

Medication:	Strength:	Frequency:	Qty:	Refill(s):
Case Specific Diagnosis/ICD10:[2]	Route of Administration: ☐ Oral ☐ IM ☐ SC ☐ Transdermal ☐ IV ☐ Other For physician administered, will this provider be ordering & administering? ☐ **Yes** ☐ **No** If no, supply administering provider:			

Please check one of the following:

This is a new medication and/or new health plan for the patient. ☐ **If checked, *go to question 1***	This is continued therapy previously covered by the patient's current health plan. ☐ **If checked, approx. date initiated _____/_____. *Go to question 5***

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**
   2.(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(s) or has the patient experienced an adverse reaction with a preferred/formulary drug(s) in the therapeutic class? If yes, complete the following: ☐ **Yes** ☐ **No**

Drug and Dose	Route	Frequency	Approx. date range therapy began & stopped	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? If yes, explain: ☐ **Yes** ☐ **No**

5. Is this a change in dosage/day for the above medication? ☐ **Yes** ☐ **No**
6. Does the request require an expedited review?* **Rationale**_____ ☐ **Yes** ☐ **No**
7. Attach relevant lab results, tests and diagnostic studies performed that support use of therapy. **Check if attached** ☐

Required clinical information: Please provide all relevant clinical information in the box below to support a medical necessity to determine coverage. Refer to health plan coverage requirements for the requested medication (see link above).
☐ Please check here if documentation is attached.

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

Prescriber's Signature _____ Date ___/___/_____