



New Mexico Medical Prior Authorization Form

Applicable Services:

- THERAPIES PERFORMED BY OUT-OF-NETWORK PROVIDERS
- GENDER AFFIRMING SERVICES

Do not use this form: 1) to request an appeal, 2) to confirm eligibility, 3) to verify coverage, 4) to ask whether a service requires prior authorization, 5) to request prior authorization of a prescription drug, 6) for services that require precertification other than those listed above, or 7) to request a referral to an out of network physician, facility, or other health care provider.

To file via facsimile, send to: [413-781-1958]

To file via secure email: Set up login at wellfleet-mail.com and register for secure submittal via Zix. Send requests to: priorauth@wellfleetinsurance.com.

For further information or questions, please call the phone number listed on the back of the customer's ID card or call Customer Service team (800)633-7867.

PLEASE NOTE: Determination of medical necessity will be made in an expedited manner upon receipt of this form and all necessary information. There may be a delay if additional information is needed. Wellfleet may utilize independent review organizations. *Wellfleet utilizes utilization management (UM) vendors for services that require pre-certification, separate from the "Applicable Services" noted at the top of this form. Clinical review criteria and information on how to submit pre-certification requests to UM vendors may be found <https://wellfleetstudent.com/forms>.

New Mexico Uniform Prior Authorization Form

To file electronically, send to: [INSERT WEB ADDRESS HERE] **To file via facsimile, send to:** [INSERT FAX NUMBER HERE]

To contact the coverage review team for [INSERT PLAN NAME], please call [INSERT PHONE NUMBER] between the hours of [INSERT HOURS].
For after-hours review, please contact [INSERT PHONE NUMBER].

[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: Ordering Provider Rendering Provider 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. 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 Inpatient Home Office 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? Yes 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: _____

[8] 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? 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 _____