truehealth new mexico

New Mexico Uniform Prior Authorization Form

To contact the coverage review team for True Health New Mexico, please call 1-844-508-4677 between the hours of 8:00 a.m. and 5:00 p.m. For after-hours review, please contact 1-844-508-4677.

Department	Fax this Form to	Phone Number	To File Electronically, Send to
Medical/Behavioral Health	1-866-446-3774	1-844-508-4677	https://thnm.alderaplatform.com
Pharmacy	1-866-718-7938	1-866-823-1606	https://account.covermymeds.com/login

[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 extension:	j. Facsimile/email:
k. Rendering provider name:	l. Rendering provider type/specialty:	m. Rendering provider NPI #:
n. Rendering provider street address:	o. Rendering provider city, state, zip code:	p. Rendering provider phone number/ext.:
q. Rendering provider fax number:	r. Rendering provider 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 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:

[7] 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 & 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:

m. Rationale for drug formulary or step-therapy exception request:

☐ **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).

☐ **Patient is stable on current drug(s)**, high risk of significant adverse clinical outcome with medication change. Specify anticipated significant adverse clinical outcome below.

☐ **Medical need for different dosage and/or higher dosage**, specify below: (1) dosage(s) tried; (2) explain medical reason.

☐ **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.

☐ **Other** (explain below)

Required explanation(s):

n. List any other medications patient will use in combination with requested medication:

o. 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 _____