Prior Authorization Request

MC-Rx
Powered by ProCare Rx

Instructions: Use this form to submit a claim for a drug that requires PRIOR AUTHORIZATION, or is subject to a STEP THERAPY or a QUANTITY LIMIT, or to dispense a supply due to a patient's upcoming trip.

All requests must include a copy of the prescription and any other document related to the authorization process. For example, patient's drug history profile, a medical justification for the prescribed therapy, lab results, or evidence of an upcoming trip. This request and all supporting documents will be submitted by fax to MC-Rx for processing. Please refer to the table below for information on fax numbers per client.

Client	Fax
MC-Rx MAPFRE, BPPR, BMS, MMM EMPLOYEES, WALMART	1(866) 245-5057
ADAP HIAP	1(866) 785-0069
MC-Rx Plan de Salud VITAL (PSG)	1(866) 247-2880
MC-Rx MCS	1(888) 383-1960

Pharmacy Information

Pharmacy Name:

NCPDP or NPI #:
(provide one or the other)

Pharmacy Phone or Fax:
(provide one or the other)

Member's Information

Member ID #:

Service Date (mm/dd/yyyy):

Member's Full Name:

Select the name of the Members' plan
- [ ] BPPR [ ] BMS [ ] MC-Rx MAPFRE [ ] MC-Rx MCS [ ] MC-Rx PSG VITAL
- [ ] MMM Employees [ ] WALMART

Prescription Information

Drug Name:

Drug Strength

Select the reason for this request
- [ ] DUR [ ] REQUIRES PA [ ] QUANTITY LIMIT [ ] STEP THERAPY
- [ ] PATIENT HAS A TRIP (evidence must be submitted along with this request)

Complete all applicable fields.

Diagnoses or ICD-10 diagnostic codes: ,

Did the prescriber provide a medical justification? [ ] YES [ ] NO
If YES, include a copy of the justification along with this request.

If Step Therapy, does the patient show prior use of a Step 1 or Step 2 option? [ ] YES [ ] NO

If yes, please write the names of the drug(s) used by the patient.

For drugs that are dosed by weight, height and or BSA (ex. chemotherapies, anti-hemophilic agents), please provide:

Weight   Height   BSA

Was the prescriber contacted? [ ] YES [ ] NO

Name of the Pharmacist who contacted the prescriber:

Pharmacist's Signature

Date (mm/dd/yyyy):

! **Important:** Remember to **sign the request**, **include all supporting documents AND the prescription**. Contact MC-Rx's Pharmacy Call Centers if you need assistance.

Pharmacy Network Call Center 1(888) 311-6001
Prior Authorization Call Center 1(866) 999-6221
24 / 7 Service Hours

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