

**NEW YORK STATE MEDICAID PROGRAM
PRIOR AUTHORIZATION INSTRUCTIONS FOR PRESCRIBERS**

CLINICAL DRUG REVIEW PROGRAM

Prior Authorization Call Line 1- 877- 309- 9493

PROGRAM INFORMATION

- ♦ Drugs included in the Clinical Drug Review Program require prior authorization.
- ♦ A list of CDRP drugs is available at www.nyhealth.gov and at <http://newyork.fhsc.com>.
- ♦ Under the CDRP, only the prescriber, not an authorized agent, must call the prior authorization call line to initiate a prior authorization.
- ♦ Fax requests are **NOT** permitted for the Clinical Drug Review Program.
- ♦ When calling the staffed clinical call center, a pharmacy technician or a pharmacist will ask for specific clinical information.

PRESCRIBER PROCEDURE

- ♦ To initiate the prior authorization process, the prescriber must call the prior authorization phone line at **1-877-309-9493** and select **Option “1”** for Prescriber.
- ♦ Select **Option “1”** again to obtain a prior authorization for a CDRP drug. Please be prepared to provide the following information when calling:
 - ♦ Prescriber’s Medicaid ID number or license number
 - ♦ Recipient’s Medicaid ID number
 - ♦ CDRP drug name
- ♦ Each CDRP drug has specific clinical information that must be provided before a prior authorization will be issued. The clinical criteria relevant to each specific CDRP drug are listed at the end of the prior authorization worksheet.
- ♦ If uncertain which selection to make or if assistance with the prior authorization process is required, select **Option “3”** for assistance.
- ♦ Once authorization is given and a prior authorization number is obtained, the number must be written on the face of the prescription. Please be sure to include the “W” when writing the prior authorization number on the patient’s prescription.

For billing questions, call 1-800-343-9000

For clinical concerns or Clinical Drug Review Program questions, visit www.nyhealth.gov and <http://newyork.fhsc.com> or call 1-877-309-9493

For Medicaid pharmacy policy and operations questions, call (518) 486-3209

**NEW YORK STATE MEDICAID PROGRAM
PRIOR AUTHORIZATION WORKSHEET FOR PRESCRIBERS**

CLINICAL DRUG REVIEW PROGRAM

Prior Authorization Call Line 1- 877- 309-9493

RECIPIENT INFORMATION			
Recipient Name:		Street:	
Recipient Medicaid ID#: (2 letters, 5 numbers, 1 letter)		City:	State: Zip:
PRESCRIBER INFORMATION			
Prescriber Name:		Contact Person:	
Prescriber ID Number (MMIS) _____ OR License NYS Physician /PA/Resident: 0 0 _____ NYS Optometrist: U _____ or V _____ _____ NYS Nurse Practitioner/Midwife: F _____ NYS Dentist: 0 0 0 _____ NYS Podiatrist: 0 0 0 0 _____ OR Out-of-State License: _____ (Use your state abbreviation in the first two spaces.)		Street:	
		City:	State: Zip:
		Office Phone#:	Office Fax #:
DIAGNOSIS AND MEDICAL INFORMATION			
Drug Name:	Strength and Route of Administration:		Frequency:
<input type="checkbox"/> New Prescription OR Date Therapy Initiated:	Expected Length of Therapy:		Qty:
Height/Weight:	Drug Allergies:	Diagnosis:	
Prescriber's Signature:			Date:
CLINICAL CRITERIA SPECIFIC TO A CDRP DRUG MUST BE COMPLETED FOR PRIOR AUTHORIZATION			
Clinical criteria relevant to each specific CDRP drug is available on the proceeding pages, and must be completed before prior authorization will be given.			
PRIOR AUTHORIZATION NUMBER			
Prior Authorization Number (11 digits): _____			

The attached mandatory Clinical Criteria must be completed
before a prior authorization will be issued.

DO NOT FAX THIS FORM

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CLINICAL CRITERIA

REVATIO:

Are you the practitioner on record primarily responsible for the management of the condition requiring the use of Revatio for this patient?
Are you currently board certified in Pulmonary or Cardiovascular disease or is there documentation in the patient's medical record of an evaluation by a physician, board certified in Pulmonary or Cardiovascular disease?
What is the diagnosis documented in the patient's chart that requires treatment with Revatio?
Mean Pulmonary Artery Pressure (either at rest or with exercise): _____ Pulmonary artery occlusion pressure: _____ Acute pulmonary vasoreactivity (as determined during right catheterization): _____
*Alternative-fax RHC report to 1-800-268-2990
What NYHA/WHO classification describes the patient's current functional status?
Before prescribing this drug, have you inquired about regular or intermittent therapy with nitrates or drugs containing nitrates within the past 180 days, and completed counseling of this patient including strong warning against the use of any drugs containing nitrates in conjunction with Revatio?
Is this patient currently using an oral erectile dysfunction medication?
Have you evaluated for retinitis pigmentosa and completed counseling on the risk of ocular disturbances, non-arteric anterior ischemic optic neuropathy (NAION) and potential for blindness?

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