Prescription Drugs Transition of Care Benefits Request

For MVP Health Care® Commercial Plan Members

When you are new to MVP, transition of care benefits may allow you to fill a one-time, 30-day (or less) supply of a prescription drug if you need prior authorization or the drug is not on the MVP Formulary. The MVP Formulary is a list of drugs covered by your plan.

A transition supply helps give you time to work with your prescribing provider to find a drug alternative or get a prior authorization. Your provider can initiate and submit a *Prior Authorization Request* using the MVP online Prior Authorization tool, faxing a *Prior Authorization Request* to MVP, or via **CoverMyMeds.com**. The following restrictions apply:

- This request can only be used within the first 60 days of the date your MVP benefit started
- This request can only be used for requesting a prescription drug filled at a pharmacy. MVP reserves the right to review this request for medical necessity and appropriateness

To avoid disruptions in your care, requests should be submitted to MVP prior to your enrollment

Instructions for Completing this Request

This is only used to request transition of care benefits for prescription drugs you obtain directly from a pharmacy. If you obtain any medications directly from your provider, you must complete the *MVP Transition of Care Benefits Application* to request the medication. To download the application, visit **mvphealthcare.com** and select *Resources*, then *Forms*.

Review the current medications you receive from a pharmacy and identify any you take that are not currently on your MVP Formulary or that require prior authorization. To view your plan's current Formulary, visit **mvphealthcare.com/prescriptions** and enter the *State*, *Year*, and *Plan*.

Submit this completed Request to MVP by fax to **1-800-376-6373**, or mail it to: ATTN: PHARMACY DEPT, MVP HEALTH CARE, 625 STATE ST, SCHENECTADY NY 12305-2111.

Section 1: Member Information *(Please print)*

Member Name *(first, middle, last)*

MVP Member ID No. *(optional)*

Date of Birth

Member Effective Date

Member Phone No. ( )

Employer Group Name

Prescribing Provider Name

Phone No. ( )

Pharmacy Name

Phone No. ( )

Section 2: Prescription Drug Information *(Please print)*

Medication Name and Strength	Quantity per 30-Day Supply	Prior Authorization Required with Current Health Plan?
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No