Magellan Rx Management Prior Authorization Request Form

Fax completed form to: 1-888-656-3251
If you have questions or concerns, please call: 1-800-424-8115
For faster prior authorization processing, please log on to: ih.magellanrx.com

MEDICA®

Patient Information

Last Name:	First Name:	DOB:

Address:	City	State	Zip

Daytime Phone:	Evening Phone:	Cell Phone

Insurance Information * Submit copy of the prescription benefit card *****

Prescription Benefit ID #	Group #

Ordering Physician Information

Name:	Specialty:	NPI / TIN:

Address:	Phone #:	Secure Fax #:

Rendering Physician Information (if different from Ordering Physician)

Name:	Specialty:	NPI / TIN:

Address:	Phone #:	Secure Fax #:

Primary Diagnosis

Primary Diagnosis Code: _____ ☐ Other:_____

Clinical Information – Please attach pertinent documentation to assist with approval process

Initial date of therapy:_____ Patient Weight (kg): _____ Height: _____ Chronological Age: _____ yr. _____mo.

☐ **New Therapy** ☐ **Continuing Therapy;** If continuing, how long has patient been on therapy? _____

Is the patient tolerating the therapy well? ☐Yes ☐ No

Has the patient shown beneficial response to this medication: ☐Yes ☐ No

Has the patient failed or had inadequate response to previous therapies for this diagnosis: ☐Yes ☐ No

Previous Therapy (include drug, dose, and duration):

1. _____ Date of trial:_____
2. _____ Date of trial: _____

Reason for Discontinuing Previous Therapy:

Allergic reaction **(please specify, may submit progress notes to support):** _____

_____

Contraindication(s) (list conditions):_____

Drug interaction(s) (please specify): _____

Therapeutic Failure **(may provide lab data, discharge summaries, or progress notes to support):** _____

_____

Additional relevant clinical information:_____

Reason for Referral: _____

Medical Records and Labs (will need to be faxed in along with lab values – labs should be within 30 days of request)

Prescription Information

DRUG NAME/STRENGTH	HCPCS	DOSING & FREQUENCY INSTRUCTIONS

Information on this form is accurate as of this date: ___/___/___ **Prescriber's Signature:**_____

Magellan Rx MANAGEMENT℠