Prescription Drug Prior Authorization Form

Fax this form to: 1-800-424-3260

A fax cover sheet is not required.

Magellan Rx MANAGEMENT

Instructions: Please fill out all applicable sections on all pages completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the prior authorization). **Information contained in this form is Protected Health Information under HIPAA.**

☐ **NON-URGENT** ☐ **EXIGENT CIRCUMSTANCES**

MEMBER INFORMATION

Member's Last Name:

Member's First Name:

Date of Birth: – –

Phone Number: – –

Member's Address:

City:

State:

ZIP:

Sex: ☐ **Male** ☐ **Female** **Height:** _____ **(in./cm)** **Weight:** _____ **(lb./kg)**

Allergies: _____

If you are not the member or the prescriber, you will need to submit a PHI Disclosure Authorization form with this request which can be found at the following link:
https://magellanrx.com/member/external/commercial/common/doc/en-us/PHI_Disclosure_Authorization.pdf

MEMBER'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____

Authorized Representative Phone Number: – –

INSURANCE INFORMATION

Primary Insurance Name:

Member ID Number:

Secondary Insurance Name:

Member ID Number:

(Form continued on next page.)

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Member's Last Name: **Member's First Name:**

PRESCRIBER INFORMATION

Prescriber's Last Name: **Prescriber's First Name:**

Prescriber's Specialty: **Email Address:**

National Provider Identifier (NPI) Number: **DEA Number:**

Office Phone Number: – – **Office Fax Number:** – –

Prescriber's Address:

City: **State:** **ZIP:**

Requester (if different than provider):

Office Contact Person:

MEDICATION / MEDICAL AND DISPENSING INFORMATION

Drug Name/Form: _____

Dosing Frequency: _____

Length of Therapy: _____

Number of Refills: _____

Quantity per Day: _____

☐ **New Therapy** ☐ **Renewal**

If Renewal, what date was therapy initiated? _____

If Renewal, what was the duration of therapy (specific dates)? _____

(Form continued on next page.)

 MHID: MRXCOM01_01

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Member's Last Name: **Member's First Name:**

MEDICATION / MEDICAL AND DISPENSING INFORMATION *(CONTINUED)*

How did the member receive the medication?

☐ **Paid Under Insurance**

Insurance Name: _____

Prior Authorization Number (if known): _____

☐ **Other (explain):** _____

Administration:

☐ Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Other: _____

Administration Location:

☐ Member's Home ☐ Long Term Care ☐ Physician's Office

☐ Home Care Agency ☐ Ambulatory Infusion Center ☐ Outpatient Hospital Care

☐ Other (explain): _____

DIAGNOSIS AND MEDICAL INFORMATION

1. Has the member tried any other medications for this condition?

   ☐ Yes ☐ No

   If **Yes:**

   What was the medication therapy (specify drug name and dosage)?

   _____

   What was the duration of therapy (specify dates)?

   _____

   What was the response, reason for failure, or allergy?

   _____

2. What are the member's diagnoses and ICD-10 codes?

   Diagnoses: _____

   ICD-10 Codes: _____

(Form continued on next page.)

 MHID: MRXCOM01_01

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Member's Last Name: **Member's First Name:**

3. What additional clinical information do you have that is relevant to this request for a prior authorization? Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if the member has any contraindications for the health plan/insurer preferred drug. Lab results with dates must be provided if needed to establish diagnosis or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage, including information related to exigent circumstances, or required under state and federal laws.

☐ **Attachments**

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature (Required) ***Date***

(By signature, the Physician confirms the above information is accurate and verifiable by patient records.)

Fax this form to: 1-800-424-3260

Mail requests to:
Magellan Rx Management Prior Authorization Program
c/o Magellan Health, Inc.
4801 E. Washington Street
Phoenix, AZ 85034
Phone: 1-800-424-3312

 MHID: MRXCOM01_01