Magellan Rx Management Prior Authorization Request Form

Fax completed form to: 1-888-656-6671
If you have questions or concerns, please call: 1-800-424-8231
For faster prior authorization processing, please log on to: ih.magellanrx.com

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 #

Benefit Configuration (if applicable)

☐ **Medical:** Ship to Prescriber for Administration in Office
Dispensing Pharmacy:

☐ **Medical:** Office to Buy & Bill

☐ **Pharmacy:** Patient will obtain the medication for self-administration, **OR** patient will obtain the medication for administration at the physician's office, infusion center, or via homecare provider (Provider agrees to accept medication from patient for administration in office, facility, or via homecare provider)
Dispensing Pharmacy:

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:____

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:**____________________________________