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DMBA

Prescription Drug Prior Authorization Form

Instructions: Please fill out all applicable sections on both 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

Last Name: **First Name:**

Phone Number: – – **Date of Birth:** – –

Street Address:

City: **State:** **Zip Code:**

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

If you are not the patient 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

Patient's Authorized Representative (if applicable): _____

Authorized Representative Phone Number:

– –

Insurance Information

Primary Insurance Name: **Patient ID Number:**

Secondary Insurance Name: **Patient ID Number:**

Prescriber Information

Last Name: **First Name:**

NPI Number: **DEA Number:**

Specialty: **Email Address:**

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

Street Address:

City: **State:** **Zip Code:**

Requestor *(if different than Prescriber)*: **Office Contact Person:**

Magellan Rx MANAGEMENT℠

Prescription Drug Prior Authorization Form

Member's Last Name: | | | | | | | | | | | | |

Member's First Name: | | | | | | | | | | | | |

Medication / Medical and Dispensing Information

Drug Name: _____ Dose/Strength: _____

Frequency: _____ Length of Therapy/#Refill: _____ Quantity: _____

Directions for Use: _____

☐ New Therapy ☐ Renewal **If Renewal:** Date Therapy Initiated: _____ Duration of Therapy (dates): _____

1. How did the patient receive the medication?

☐ Paid under Insurance Name: _____ Prior Auth Number (if known): _____

☐ Other (explain): _____

2. Administration:

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

3. Administration Location:

☐ Physician's Office ☐ Home Care Agency ☐ Other (explain): _____

☐ Ambulatory Infusion Center ☐ Outpatient Hospital Care _____

☐ Patient's Home ☐ Long Term Care _____

4. Has the patient tried any other medications for this condition? ***If YES, complete questions below.*** ☐ Yes ☐ No

5. Has the patient tried any other medications for this condition? ☐ Yes ☐ No

a. **Specify Drug and Dosage:** _____

b. **Duration of Therapy (specify Dates):** _____

c. **Response/Reason for Failure/Allergy:** _____

6. List Diagnoses: _____

7. ICD-10: _____

Required Clinical Information *– Provide all relevant clinical information to support a prior authorization*

Provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if patient 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. 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 or Electronic I.D. Verification: _____ **Date:** _____

Fax this form to: 1-888-656-7789

Mail requests to: Magellan Rx Management Prior Authorization Program; c/o Magellan Health, Inc.
PO Box 1599
Maryland Heights, MO 63043
Phone: 1-877-879-9922