Magellan Rx Management Prior Authorization Request Form

Fax completed form to: 1-888-656-3251
If you have questions, please call: 1-800-424-8115
For faster prior authorization processing, please submit your requests at www.mrxgateway.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 insurance card ***	
Member ID #	Group #

Ordering Physician Information		
Name	TIN	NPI
Address	Phone #	Secure Fax #

Rendering Provider Information (or Specialty Pharmacy, if applicable)		
Name	TIN	NPI
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: _____

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

Is the patient tolerating the therapy well with minimal to no side effects? ☐ 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: Please include any pertinent medical records along with the **most recent** lab values.

Prescription Information

Drug Name & Strength	Loading Dose & Pattern
HCPCS	**Maintenance Dose & Frequency**

Place of Service	Other Information
☐ **Office** ☐ **Home Infusion** ☐ **Outpatient Hospital** ☐ **Other (specify)** _____	☐ **Drug will be self-administered**

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

Magellan Rx MANAGEMENT℠