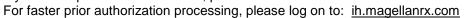
Magellan Rx Management Prior Authorization Request Form

Fax completed form to: 1-888-656-6671

If you have questions or concerns, please call: 1-800-424-8231





Patient Information Last Name:	First Name:					DOB:		
Address:	City				<u> </u>	State	Zip	
Daytime Phone:	Evening Phone: Cell				one	l	<u> </u>	
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 ☐ Medical: Office to Buy & Bill				l				
Dispensing Pharmacy:								
□ 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:			1	NPI / TIN:			
Address		Dho	#·		Coor	vo Fov #		
Address:		Pho	ne #:		Secur	e Fax #:		
Rendering Physician Information (if different from Ordering Physician)								
Name:	Specialty:				NPI / TIN:			
Address:		Pho	ne #:	L	Secur	re 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: _		Chrono	ological Age:	У	rmo.		
□ New Therapy □ Continuing Therapy; If continuing, how long has patient been on therapy?								
Is the patient tolerating the therapy well? \square Yes \square No Has the patient shown beneficial response to this medication: \square Yes \square 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		nos	ING & FREQUEN	ICA ING	TRUCTIONS		
D. CO. IV. III. DOTALINO III	.5. 00		500	G G I NEGOLI				
Information on this form is accurate as of this date:// Prescr	iber's Signature							

