

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



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: _____ <input type="checkbox"/> Other: _____						
Clinical Information – Please attach pertinent documentation to assist with approval process						
Initial date of therapy: ____ / ____ / ____ Patient Weight (kg): _____ Height: _____						
<input type="checkbox"/> New Therapy <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Has the patient shown beneficial response to this medication? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Has the patient failed or had inadequate response to previous therapies for this diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> 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		
<input type="checkbox"/> Office <input type="checkbox"/> Home Infusion <input type="checkbox"/> Outpatient Hospital <input type="checkbox"/> Other (specify) _____				<input type="checkbox"/> Drug will be self-administered		
Information on this form is accurate as of this date: ____ / ____ / ____ Prescriber's Signature: _____						