



# General Prior Authorization Request Form for Medications

Please fax all Prior Authorization requests for medications to the Magellan Pharmacy Helpdesk at **866-498-0628**  
Only one medication request per form • All fields must be complete and legible for review

*If the request is urgent, please call 800-790-1631.*

**All requests for reconsideration, regardless of reason, should be faxed to 866-498-0628 clearly marked "Reconsideration Request"**

PRESCRIBER	PRESCRIBER NPI	RECIPIENT	RECIPIENT ID NUMBER (CIS OR AHCCCS ID)
	PRESCRIBER NAME		RECIPIENT NAME
	PRESCRIBER SPECIALTY		RECIPIENT DATE OF BIRTH (MM/DD/YYYY)
	CLINIC NAME		FEMALE    MALE
	OFFICE PHONE		RECIPIENT SEX (CIRCLE)      HEIGHT      WEIGHT
	OFFICE FAX		RECIPIENT PHONE
	CONTACT NAME		RECIPIENT DIAGNOSIS (AXIS I – III)
RECIPIENT DRUG ALLERGIES			

REQUEST	MEDICATION NAME	STRENGTH AND FORM	ROUTE OF ADMINISTRATION	FREQUENCY
	DATE THERAPY INITIATED (MM/DD/YYYY)	EXPECTED LENGTH OF THERAPY	QUANTITY PER FREQUENCY	

*List alternate drug(s) contraindicated or previously tried, but with adverse outcome(s) (e.g. toxicity, allergy, or therapeutic failure)*

RATIONALE FOR EXCEPTION OR PRIOR AUTHORIZATION	1    MEDICATION NAME	ADVERSE OUTCOME	DOSE AND DURATION OF THERAPY
	2    MEDICATION NAME	ADVERSE OUTCOME	DOSE AND DURATION OF THERAPY
	3    MEDICATION NAME	ADVERSE OUTCOME	DOSE AND DURATION OF THERAPY
	4    MEDICATION NAME	ADVERSE OUTCOME	DOSE AND DURATION OF THERAPY
	LIST CURRENT MEDICATIONS AND DOSES		
TARGET SYMPTOM / INDICATION FOR REQUESTED MEDICATION			
CLINICAL RATIONALE FOR TREATMENT			
PRESCRIBER'S SIGNATURE	DATE		

*By signing this form, the prescriber is attesting that documentation supporting the above information is recorded in the Patient's Medical Chart.*

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