MAGELLAN HEALTH SERVICES®
Getting Better All the Time™

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

PRESCRIBER NAME

PRESCRIBER SPECIALTY

CLINIC NAME

OFFICE PHONE

OFFICE FAX

CONTACT NAME

RECIPIENT

RECIPIENT ID NUMBER (CIS OR AHCCCS ID)

RECIPIENT NAME

RECIPIENT DATE OF BIRTH (MM/DD/YYYY)

FEMALE MALE
RECIPIENT SEX (CIRCLE) HEIGHT WEIGHT

RECIPIENT PHONE

RECIPIENT DIAGNOSIS (AXIS I – III)

RECIPIENT DRUG ALLERGIES

REQUEST

MEDICATION NAME | STRENGTH AND FORM | ROUTE OF ADMINISTATION | FREQUENCY

DATE THERAPY INITIATED (MM/DD/YYYY) | EXPECTED LENGTH OF THERAPY | QUANTITY PER FREQUENCY

RATIONALE FOR EXCEPTION OR PRIOR AUTHORIZATION

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

❶
MEDICATION NAME | ADVERSE OUTCOME | DOSE AND DURATION OF THERAPY

❷
MEDICATION NAME | ADVERSE OUTCOME | DOSE AND DURATION OF THERAPY

❸
MEDICATION NAME | ADVERSE OUTCOME | DOSE AND DURATION OF THERAPY

❹
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.