



Maricopa RHBA General Prior Authorization Request Form

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	RECIPIENT
PRESCRIBER NPI	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)

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
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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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