Medication Prior Authorization Request Form

Magellan Rx MANAGEMENT℠

Your request cannot be processed without complete information which includes provider specialty.

Member Information

Member name:		Member ID:
Date of birth:	Sex: ◯ Female ◯ Male	☐ **Expedited/Urgent **By checking this box, I certify applying the standard review time frame may jeopardize the health of the member or the member's ability to regain maximum function.

Provider Information

Provider name:		Provider NPI#:
Phone:	Fax:	Specialty:
Name & title of person completing form:		

Medication Information

Drug name	Strength	Administration schedule	Length of therapy	Quantity required

Patient diagnosis for use of medication

Previous history of a medical condition, allergies or other pertinent medical information that necessitates use of this medication:

Has the patient been seen by any other provider for this condition? ◯ Yes ◯ No If so, what what the prescriber's specialty:

Previous non-prior authorized and prior authorized medications tried and failed for this condition:		
Name of medication	Reason for failure	Date

Pertinent laboratory test or procedure (if applicable)		
Procedure	Findings	Date

Other Information:

To Prescriber- Complete ENTIRE form and send to:

Magellan Rx Prior Authorization Department
2520 Industrial Row Dr, Troy, MI 48084
Phone: 1-248-540-6686
Fax: 1-888-656-3604

The fax number is only for prior authorization requests.
Pharmacy will only accept original prescription orders from patients.
Faxed prescriptions can be accepted if faxed to the member's pharmacy by the prescribing physician.