

# Medication Prior Authorization Request Form



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  <small>**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.</small>

## 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 was 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.