Print Reset

Magellan Rx MANAGEMENT

NC Medicaid
Prescription Standard Drug Prior Authorization Form

Fax this form to 866-422-8981

Please fill out all applicable sections on all pages completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the prior authorization). Information contained in this form is Protected Health Information under HIPAA.

REQUESTER INFORMATION

Requester Last Name: _____

Requester First Name: _____

Requester Phone: _____ Requester Fax: _____ Date: _____

BENEFICIARY INFORMATION

Beneficiary Last Name: _____

Beneficiary First Name: _____

Beneficiary ID: _____ Date of Birth: _____ Beneficiary Phone: _____

Sex: ☐ Male ☐ Female

Allergies: _____

PRESCRIBER INFORMATION

Prescriber Last Name: _____

Prescriber First Name: _____

Specialty: _____ Prescriber NPI: _____

Prescriber Phone: _____ Prescriber Fax: _____

DRUG INFORMATION

Drug Name: _____ Drug Form: _____

Drug Strength: _____ Dosing Frequency: _____

Length of Therapy: _____ Quantity: _____

Number of Refills: _____ Day Supply: _____

☐ New Therapy ☐ Renewal If renewal, date therapy initiated: _____

If renewal, duration of therapy (specific dates): _____ to _____

Beneficiary's Full Name: _____

DISPENSING INFORMATION

Administration:

☐ Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Other: _____

DIAGNOSIS AND MEDICAL INFORMATION

1. What are the member's diagnoses and ICD-10 codes?

   Diagnoses: _____

   ICD-10 codes: _____

2. If the medication is non-preferred, please complete the following checklist and indicate all that apply to the beneficiary:

   Trial and failure of at least two preferred drugs, or at least one preferred drug if only one is available?

   ☐ Yes ☐ No

   If **YES**, list preferred drug(s) failed: _____

☐ Documented allergy or drug-to-drug interaction with preferred medications. Provide details (e.g., duration of therapy, specific dates, etc.).

_____

☐ Documented history of unacceptable side effect(s) to preferred medications. Provide details (e.g., duration of therapy, specific dates, etc.).

_____

☐ Documented clinical contraindication or co-morbidity to preferred medications. Provide details (e.g., duration of therapy, specific dates, etc.).

_____

☐ A unique clinical indication supported by the FDA or peer reviewed literature. Provide details.

_____

☐ Unacceptable clinical risk associated with therapeutic change. Provide details.

_____

☐ Other reason: _____

Beneficiary's Full Name: _____

3. Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose. Lab results with dates must be provided if needed to establish diagnosis or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage, including information related to exigent circumstances, or required under state and federal laws.

☐ Attachments

By signing this request, the prescriber attests that the information provided herein is true and accurate to the best of his/her knowledge.

Prescriber Signature: _____ **Date:** _____

Mail requests to:

Magellan Rx Management Prior Authorization Program
Attn: GV – 4201
P.O. Box 64811
St. Paul, MN 55164-0811
Phone: 844-620-6116

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