Magellan Rx Management
Prescription Drug Prior Authorization Form
Fax completed form to 1-888-656-3251.

If you have questions, please call 1-800-424-8115. **For faster prior authorization processing, please submit your requests at** www.mrxgateway.com.

PATIENT INFORMATION

Patient Last Name: ______________________________

Patient First Name: ______________________ Date of Birth: ____________

Patient Street Address: ______________________________

City: ______________________ State: _____ Zip: ____________

Patient Daytime Phone: ______________ Patient Evening Phone: ______________

Patient Cell Phone: ______________

Member ID: ______________________ Group Number: ______________________

Note: Submit copy of the insurance card.

ORDERING PHYSICIAN INFORMATION

Prescriber Last Name: ______________________________

Prescriber First Name: ______________________________

Prescriber NPI: ______________________ TIN: ______________________

Prescriber Street Address: ______________________________

City: ______________________ State: _____ Zip: ____________

Prescriber Phone: ______________________ Prescriber Secure Fax: ______________

RENDERING PROVIDER INFORMATION

Rendering Provider Last Name: ______________________________

Rendering Provider First Name: ______________________________

Rendering Provider NPI: ______________________ TIN: ______________________

Rendering Provider Street Address: ______________________________

City: ______________________ State: _____ Zip: ____________

Rendering Provider Phone: ______________________

Rendering Provider Secure Fax: ______________________

SPECIALTY PHARMACY INFORMATION

(If applicable.)

Pharmacy Name: ______________________ Pharmacy NPI: ______________

Pharmacy Phone: ______________________ Pharmacy Fax: ______________

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Patient's Name (Last, First): ______________________________

PRIMARY DIAGNOSIS

Primary Diagnosis Code: ______________________________

☐ Other: ______________________________

CLINICAL INFORMATION

Please attach pertinent documentation to assist with approval process.

Initial Date of Therapy: ____________________ (dd/mm/yyyy).

Patient Weight (kg): ____________________ Patient Height: ____________________

☐ New Therapy ☐ Continuing Therapy

If Continuing, how long has the patient been on therapy? ____________________

Is the patient tolerating the therapy well with minimal to no side effects?

☐ Yes ☐ No

Has the patient shown beneficial response to this medication?

☐ Yes ☐ No

Has the patient failed or had inadequate response to previous therapies for this diagnosis?

☐ Yes ☐ No

Previous Therapy (include drug, dose, and duration):

Drug: ______________________________ Dose: ____________________

Date of Trial (from): ____________________ Date of Trial (to): ____________________

Drug: ______________________________ Dose: ____________________

Date of Trial (from): ____________________ Date of Trial (to): ____________________

Reason for Discontinuing Previous Therapy:

☐ Allergic reaction (please specify, may submit progress notes to support):

____

☐ Contraindication(s) (list conditions): ______________________________

☐ Drug interaction(s) (please specify): ______________________________

☐ Therapeutic Failure (may provide lab data, discharge summaries, or progress notes to support):

____

Additional relevant clinical information: ______________________________

Medical Records and Labs: Please include any pertinent medical records along with the **most recent** lab values.

PRESCRIPTION INFORMATION

Drug Name: ______________________________

Drug Strength: ____________________ Quantity: ____________________

Loading Dose and Pattern: ______________________________

Patient's Name (Last, First): ______________________________

PRESCRIPTION INFORMATION (CONTINUED)

HCPCS: ______________________________

Maintenance Dose and Frequency: ______________________________

Place of Service:

☐ Office

☐ Home Infusion

☐ Outpatient Hospital

☐ Other (specify): ______________________________

Other Information:

☐ Drug will be self-administered.

FOR MINNESOTA MEMBERS ONLY

☐ Please check here if based on your clinical opinion, this member has a rare disease as outlined by the State of Minnesota based on one of the following:

A. The disease/condition affects fewer than 200,000 persons in the US and is classified as chronic, serious, life-altering, or life-threatening.

B. The disease/condition affects more than 200,000 persons in the US and/or a drug proposed for treatment has been designated as a drug for a rare disease or condition pursuant to United States Code, title 21, section 360bb.

C. The disease/condition is labeled as a rare disease or condition on the Genetic and Rare Diseases Information Center list created by the National Institutes of Health available at: https://rarediseases.info.nih.gov/diseases?category=&page=1&letter=&search=.

☐ Attachments

Information on this form is accurate as of this date: ________________ (dd/mm/yyyy).

Prescriber's Signature: ______________________________