



General Prior Authorization Request Form for Medications

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		
	PRESCRIBER NPI	RECIPIENT ID NUMBER (CIS OR AHCCCS ID)
	PRESCRIBER NAME	RECIPIENT NAME
	PRESCRIBER SPECIALTY	RECIPIENT DATE OF BIRTH (MM/DD/YYYY)
		FEMALE MALE
	RECIPIENT SEX (CIRCLE) HEIGHT WEIGHT	
CLINIC NAME	RECIPIENT PHONE	
OFFICE PHONE		
OFFICE FAX	RECIPIENT DIAGNOSIS (AXIS I – III)	
CONTACT NAME	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)

RATIONALE FOR EXCEPTION OR PRIOR AUTHORIZATION	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 _____

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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