QualChoice HEALTH INSURANCE

Prescription Drug Prior Authorization Form

Fax this form to: 1-888-904-1149

A fax cover sheet is not required.

Magellan Rx MANAGEMENT

Instructions: 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**.

☐ **NON-URGENT** ☐ **EXIGENT CIRCUMSTANCES**

MEMBER INFORMATION

Member's Last Name: **Member's First Name:**

Member ID Number: **Date of Birth:** – –

PRESCRIBER INFORMATION

Prescriber's Last Name: **Prescriber's First Name:**

National Provider Identifier (NPI) Number:

Phone Number: – – **Fax Number:** – –

Prescriber Specialty: ______________________________

MEDICATION / MEDICAL AND DISPENSING INFORMATION

Drug Name/Form: ______________________ **Strength:** ______________

Dosing Frequency and Quantity Requsted: ______________________________

Length of Therapy: ______________________________

☐ **New Therapy** ☐ **Renewal**

If Renewal, what is the date therapy was initiated? ______________________

Administration Location: ☐ Member's Home ☐ Long Term Care ☐ Physician's Office

(Form continued on next page.)

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Member's Last Name: | | | | | | | | | | | | |

Member's First Name: | | | | | | | | | | | | |

DIAGNOSIS AND MEDICAL INFORMATION

1. Has the member tried any other medications for this condition?

   ☐ Yes ☐ No

   If **Yes**:

   What was the medication therapy (specify drug name, dosage and duration of therapy)?

   ____

   What was the response, reason for failure, or allergy?

   ____

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

   Diagnoses: ____

   ICD-10 Codes: ____

3. What additional clinical information do you have that is relevant to this request for a prior authorization? Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if the member has any contraindications for the health plan/insurer preferred drug. 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**

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

____ _______________________

Prescriber Signature (Required) ***Date***

(By signature, the physician confirms the above information is accurate and verifiable by patient records.)

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