

**Atypical Therapeutic Duplication or
Child less than 5 years old
Prior Authorization Form**



REQUEST BY PRESCRIBER & BY FAX ONLY

Fax request to: (888) 603-7696 **Phone** (800) 331-4475 **Questions?** Call MMA at (800) 331-4475

Form available: <http://www.hss.state.ak.us/dhcs/pharmacy/medpriorauthoriz.htm>

Mail: Magellan Medicaid Administration, PA UNIT, 14100 Magellan Plaza, Maryland Heights, MO 63043

Note: This authorization request does not ensure eligibility and is not a guarantee of payment. Please verify Medicaid eligibility before completing this form.

Incomplete requests will be rejected until all required information is received.

Revised 7-2012

REQUESTOR	Must be requested by prescriber and by fax only. See below.	
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RECIPIENT	Last Name, First Name, Middle I.:	
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DOB:	Recipient ID:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
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PRESCRIBER	Name:	NPI: - - - - -
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Phone: ()	Fax: ()
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Specialty:	
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PHARMACY	Name:	NPI: - - - - -
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Phone: ()	Fax: ()
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REQUEST	Drug:	Strength:	Dosage Form:
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Primary Diagnosis:	Dosage schedule:
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Other Diagnoses:	QTY:	Day Supply:
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Primary Diagnosis:	Dosage schedule:
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Other Diagnoses:	QTY:	Day Supply:
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REQUIRED DOCUMENTS FOR PRIOR AUTHORIZATION	Prior Authorization start date:
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INCOMPLETE REQUESTS WILL BE REJECTED UNTIL ALL REQUIRED INFORMATION IS RECEIVED

Please provide the following information (Therapeutic Duplication):

[] Documentation of the condition being treated and that the addition of a second atypical antipsychotic is medically necessary.

AND

[] Documentation that the initial atypical antipsychotic cannot be discontinued with the addition of the second atypical antipsychotic.

AND

[] A treatment plan that includes monitoring for adverse drug reactions, metabolic side effects, and efficacy.

AND

[] Medication profile history showing at least 2 weeks of single-drug therapy at an adequate dose of the medication and progress notes.

Please provide the following information (Child less than 5 years old):

[] A treatment plan that includes monitoring for adverse drug reactions, metabolic side effects, and efficacy.

Prescriber's Signature: _____ Date: _____