Alaska Medicaid

Atypical Therapeutic Duplication, Exceeds Maximum Quantity Limits or Child less than 5 years old Prior Authorization Form

REQUEST BY PRESCRIBER & BY FAX ONLY

MAGELLAN MEDICAID ADMINISTRATION

Fax request to: **(888) 603-7696** **Phone** **(800) 331-4475** **Questions?** Call MMA at (800) 331-4475
Form available: http://dhss.alaska.gov/dhcs/Pages/pharmacy/medpriorauthoriz.aspx
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 1-2013

REQUESTOR	*Must be requested by prescriber and by fax only. See below.*	
RECIPIENT	Last Name, First Name, Middle I.:	
DOB:	Recipient ID:	Sex: ☐ Male ☐ Female
PRESCRIBER	Name:	NPI: - - - - - - - - - -
Phone: ( )		Fax: ( )
Specialty:		
PHARMACY	Name:	NPI: - - - - - - - - - -
Phone: ( )		Fax: ( )
REQUEST	Drug:	Strength: Dosage Form:
Primary Diagnosis:		Dosage schedule:
Other Diagnoses:		QTY: Day Supply:
REQUEST	Drug:	Strength: Dosage Form:
Primary Diagnosis:		Dosage schedule:
Other Diagnoses:		QTY: Day Supply:
REQUIRED DOCUMENTS FOR PRIOR AUTHORIZATION		Prior Authorization start date:

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 (Exceeds Maximum Quantity Limits):

[ ] Documentation of the condition being treated and rationale that dosing above maximum limits is medically necessary **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 dosing of medication within limits 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:_____