

# Hemophilia/Clotting Factor Form



**Fax request to: (888) 603-7696 Phone (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 denied until all required information is received.*

Revised 3/1/12

<b>REQUESTOR</b>	Requestor Name <i>(Print)</i>		Title
<b>RECIPIENT</b>	Last Name, First Name, Middle I.:		
DOB:	Recipient ID:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
<b>PRESCRIBER</b>	Name:	NPI: - - - - -	
Phone: ( )		Fax: ( )	
Specialty:			
<b>PHARMACY</b>	Name:	NPI: - - - - -	
Phone: ( )		Fax: ( )	
<b>REQUEST</b>			
Date of Service:			
Drug:			
Strength (Units/Vial):			
Dosing Schedule:			
Patient weight (Kg):			
Total units <u>needed</u> for one (1) month:			
Units <u>dispensed</u> in previous month:			
Units <u>used</u> in previous month:			
Unused units <u>remaining</u> from previous month(s):			
Units Requested (Units needed – Unused Units):			
<b>NOTES / COMMENTS</b>			

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