

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

REQUESTOR	Requestor Name <i>(Print)</i>	Title
------------------	-------------------------------	-------

RECIPIENT	Last Name, First Name, Middle I.:	
------------------	-----------------------------------	--

DOB:	Recipient ID:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
------	---------------	--

PRESCRIBER	Name:	NPI: - - - - -
-------------------	-------	----------------

Phone: ()	Fax: ()
------------	----------

Specialty:	
------------	--

PHARMACY	Name:	NPI: - - - - -
-----------------	-------	----------------

Phone: ()	Fax: ()
------------	----------

REQUEST

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):	
--	--

NOTES / COMMENTS

--