Alaska Medicaid

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*(Print)*	Title
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	
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