

Medication Prior Authorization Form

Not for Botulinum Toxin, Suboxone®/Subutex® or Synagis® requests

This form may also be used for requesting to exceed the maximum allowed units.**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 7-2011

REQUESTOR	Requestor Name <i>(Print)</i>		Title
RECIPIENT	Last Name, First Name, Middle I.:		
DOB: <small>mm/dd/yyyy</small>	Recipient ID: <small>(10-digits)</small>	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
PRESCRIBER	Name:	NPI: <small>(10-digits)</small>	
Phone: ()		Fax: ()	
Specialty:			
PHARMACY	Name:	NPI: <small>(10-digits)</small>	
Phone: ()		Fax: ()	
REQUEST	Drug:	Strength:	Dosage Form:
Primary Diagnosis		Dosage schedule:	
Other Diagnoses:		QTY:	Day Supply:
RATIONALE FOR PRIOR AUTHORIZATION		Prior Authorization start date:	
CURRENT MEDICATIONS:			
MEDICAL JUSTIFICATION (including previous failed therapies w/dates):			
Prescriber's Signature: _____			Date: _____

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