Medication Prior Authorization Request Form

Magellan Rx MANAGEMENT

Your request cannot be processed without complete information which includes provider specialty and address.

Member Information

Member Name:	Member ID:	
Address:	State:	Zip Code:
Phone:	Date of Birth:	

Provider Information

Provider Name:		Provider NPI#:	
Address:		State:	Zip Code:
Phone:	Fax:	Specialty:	

Medication Information

Medication (drug & strength):	Diagnosis:
Directions for use:	Date patient started medication (if previously used):
Name of specific medication(s) tried and failed:	
Reason for non-formulary request, and/or clinical justification for requested drug use: (Please include relevant lab values when appropriate. Note: Patient chart notes will be requested if further documentation is necessary.)	

Requesting Prescriber/Provider Signature

Date

Additional Notes:

To Prescriber- Complete ENTIRE form, SIGN and send to:

Magellan Rx Prior Authorization Department
4801 E Washington Street, Phoenix, AZ 85034
Phone: 1-800-424-3312
Fax: 1-800-424-3260

The fax number is only for prior authorization requests.
Pharmacy will only accept original prescription orders from patients.
Faxed prescriptions can be accepted if faxed to the member's pharmacy by the prescribing physician.