



**Fax to Magellan Pharmacy Solutions: (800) 424-7385**  
 Phone: (800) 424-6811

## PRESCRIPTION DRUG PRIOR AUTHORIZATION REQUEST FORM

**Instructions:** Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review (e.g. chart notes, medication history, lab results, etc.) to support the prior authorization request.

### Client Information: This must be filled out completely to ensure HIPAA compliance

First Name:	Last Name:	MI:	Date of Birth (MM/DD/YYYY):	Gender:
Client IS #:		Client Magellan #:		

### Prescriber/Furnisher Information

**Please check one:**  Psychiatrist  Physician Assistant  Nurse Practitioner  Clinical Pharmacist

First Name:	Last Name:	NPI Number (individual):	DEA Number (if required):
DMH Site/Clinic Name:	Phone Number:	Fax Number (in HIPAA compliant area):	

### Medication/Medical and Dispensing Information (one medication per PA request)

Medication Name:	Dose/Strength:	Frequency:	Length:
------------------	----------------	------------	---------

<input type="checkbox"/> New Therapy <input type="checkbox"/> Renewal If Renewal, Date Therapy Initiated:	How did the patient receive the medication? <input type="checkbox"/> Paid under insurance name: _____ <input type="checkbox"/> LA County/Indigent <input type="checkbox"/> Samples ( <i>not an acceptable justification for continuation of therapy</i> )
--	--

**Has the patient tried any other medications for this condition?**  YES (*if yes, complete below and provide documentation*)  NO

Medication/Therapy (Specify Drug Name and Dosage)	Duration of Therapy (Specify Dates)	Response/Reason for Failure/Allergy

List Diagnoses	ICD-10

**REQUIRED CLINICAL INFORMATION: Please provide all relevant clinical information (e.g. chart notes, medication history, lab results, etc.) to support the prior authorization request.**

Please attach documented symptoms, non-compliance issues and/or justification for initial or ongoing therapy or increased dose and if patient has any contraindications for the preferred drug. Please provide any additional clinical information or comments pertinent to this request for coverage or required under state and federal laws.

Attachments:

- Chart Notes (e.g. Avatar)
- Medication History (e.g. Order Connect)
- Other: \_\_\_\_\_

**Attestation:** I attest the information provided is true and accurate to the best of knowledge. I understand that the insurer or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

**Prescriber/Furnisher Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Supervising Physician's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(Required only for Physician Assistants, Clinical Pharmacists, and Nurse Practitioners)

(Prior Authorizations received on Friday after 12 p.m. will be reviewed on the next business day)

**Confidentiality Notice:** This confidential information is provided to you in accord with State Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled. This facsimile and any attached documents are considered confidential and are intended for the use of individual or entity to which it is addressed. If you received this in error, please notify us by telephone immediately at (213) 738-4725.

**LAC DMH Pharmacy Services Use Only**

Date of Decision: \_\_\_\_\_

Approved

Length: \_\_\_\_\_

Denied

Comments/Information Requested: \_\_\_\_\_

Return Fax

Comments/Information Requested: \_\_\_\_\_

