LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
hope. recovery. wellbeing.

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

PRESCRIPTION DRUG PRIOR AUTHORIZATION (PA) REQUEST FORM

Magellan Phone: (800) 424-6811

LACDMH Drug Formulary: https://dmh.lacounty.gov/for-providers/clinical-tools/pharmacy/

Client Information				
Last Name:	First Name:	MI:	Date of Birth:	☐ Male ☐ Female
IBHIS #:	Magellan ID # (if available):		Allergies:	

Prescriber Information			
Last Name:	First Name:	NPI Number (individual):	DEA Number *(if applicable)*:
DMH Site/Clinic Name:	Phone Number:	Fax Number (in HIPAA compliant area), REQUIRED:	

Medication Information			
Medication Name:	Dose/Strength:	Frequency:	Route of Administration: ☐ PO ☐ SL ☐ IM ☐ SC ☐ Transdermal
☐ New Therapy ☐ Continuation of Therapy ☐ Change in Dose	Date medication was initiated *(if applicable)*:	How did the patient previously receive the medication? *(if applicable)* ☐ Paid under insurance name: _____ ☐ Samples (***NOT*** *an acceptable justification for continuation of therapy*)	

1a. List Diagnoses:	**ICD-10:**	**1b. List Symptoms:**

2. Has the client tried formulary medications for this condition? (*if YES, complete section*) ☐ **YES** ☐ **NO**

Medication Name	**Strength/Dose**	**Duration of Therapy** (Month/Year – Month/Year)	**Response / Reason for Failure / Intolerability**

3. Is there documented history of successful therapeutic control with requested medication? ☐ **YES** ☐ **NO**

(If YES, provide date of medication initiation, assessment of interim adherence, and recent assessment of clinical response)

4. REQUIRED: Please PROVIDE JUSTIFICATION for why formulary medications are not adequate for client. Please also provide any additional clinical information or comments pertinent to this request for coverage, including extenuating circumstances, etc.

5. REQUIRED: ATTACH DOCUMENTATION (i.e. chart notes, medication administration/dispense history, lab results, etc.) to support answers to questions 1-4 above.

Attestation: I attest the information provided is true and accurate to the best of my 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's Signature: _____ **Date:** _____

Supervising Physician's Signature: _____ **Date:** _____
(Required for Physician Assistants and Nurse Practitioners)

(Prior Authorizations received on Friday after 12:00 p.m. PST will be reviewed the next business day)