

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: | <input type="checkbox"/> Male <input type="checkbox"/> 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), <u>REQUIRED</u> : | | |
| Medication Information | | | | |
| Medication Name: | Dose/Strength: | Frequency: | Route of Administration: <input type="checkbox"/> PO <input type="checkbox"/> SL <input type="checkbox"/> IM <input type="checkbox"/> SC <input type="checkbox"/> Transdermal | |
| <input type="checkbox"/> New Therapy <input type="checkbox"/> Continuation of Therapy <input type="checkbox"/> Change in Dose | Date medication was initiated (if applicable): | How did the patient previously receive the medication? (if applicable) <input type="checkbox"/> Paid under insurance name: _____ <input type="checkbox"/> 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) <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | |
| Medication Name | Strength/Dose | Duration of Therapy <small>(Month/Year – Month/Year)</small> | Response / Reason for Failure / Intolerability | |
| | | | | |
| 3. Is there documented history of successful therapeutic control with requested medication? <input type="checkbox"/> YES <input type="checkbox"/> 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)

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