Magellan Rx Medicare

General Prior Authorization Form

All information below is required to process this request. This request may be denied or delayed if all required information is not received.
Send completed fax form to: 800.424.5872.
If you are not the enrollee, attach documentation showing the authority to represent the enrollee (a completed authorization of Representative FORM CMS-1696 or a written equivalent). For more information on appointing a representative, contact MagellanRx Medicare at 800.424.5870 or 1-800-Medicare.

Member Information

LAST NAME: **FIRST NAME:**

ID NUMBER: **DATE OF BIRTH:** – –

ADDRESS:

CITY: **STATE:** **ZIP CODE:**

PHONE NUMBER: – – **FAX NUMBER:** – –

Provider Information

LAST NAME: **FIRST NAME:**

NPI NUMBER: **SPECIALTY:**

ADDRESS:

CITY: **STATE:** **ZIP CODE:**

PHONE NUMBER: – – **FAX NUMBER:** – –

E-MAIL ADDRESS (IF AVAILABLE):

CONTACT PERSON (If Different From Provider):

CONTACT PERSON PHONE NUMBER: **CONTACT PERSON FAX NUMBER:** – –

Are you the Enrollee? ☐ Yes ☐ No
(If no, fill in information below)
Requestor: _____ Address: _____
Relationship to Enrollee: _____ City: _____ State: _____
Contact Number: _____ Zip Code: _____

Required Medical Information

Drug/Product Name: _____ Strength: _____ Form: _____ Frequency: _____

Directions: _____ Diagnosis:

Requesting Brand? ☐ Yes ☐ No

Is this request for a continuation of therapy? ☐ Yes ☐ No

If yes, what date was therapy started? _____

Height: _____ Weight: _____ ICD10 Codes: _____

The document and attached information contain information that is privileged and confidential. It may contain Protected Health Information (PHI).
The Provider named above is required to safeguard PHI by applicable laws.

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Type of Coverage Determination Request (Required)

Note: If you are asking for a Formulary, Quantity Limit, or Tiering exception, your prescriber **MUST provide a written supporting statement for your request. Requests that are subject to prior authorization (or any other utilization management requirement, may require supporting information. Formulary, Quantity or Tiering exception requests cannot be processed without a prescriber's supporting statement. Prior authorization requests may require supporting information.

☐	I need a drug that is not on the plan's list of covered drugs (Formulary exception).**	☐	I request a prior authorization for the drug my prescriber has prescribed. (Prior Authorization)
☐	I have been using a drug that was previously included on the plan's list of covered drugs, but is being removed or was removed from this list during the plan year (Formulary exception).**	☐	My drug plan charged me a higher co-payment for a drug than it should have.
☐	I request an exception to the requirement that I try another drug before I get the drug my prescriber prescribed (Formulary exception).**	☐	I want to be reimbursed for a covered prescription drug that I paid for out of pocket.
☐	I request an exception to the plan's limit of the number of pills (quantity limit) I can receive so that I can get the number of pills my prescriber prescribed (Quantity limit exception).**	☐	I request a step therapy for the drug my prescriber has prescribed. (Step Therapy)
☐	My drug plan charges a higher co-payment for the drug my prescriber prescribed than it charges for another drug that treats my condition, and I want to pay the lower co-payment (Tier exception).**	☐	I request a step exception to the step therapy requirements.

Additional information we should consider (attach any supporting documents):

If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting 72 hours could seriously harm your health, we will give you a decision within 24 hours. If you do not obtain your prescribers support for an expedited request, we will decide if your case requires a fast decision. You cannot request an expedited coverage determination if you are asking us to pay you back for a drug you already received.

☐ **Check if you believe you need a decision within 24 hours (If you have a supporting statement from your prescriber, attach it to this request).**

High Risk Medications

The following drugs are considered a high risk medication (HRM) by CMS and should be avoided in the elderly. Safer alternatives may be available on the formulary.

HRM Drugs: ascomp-codeine, amitriptyline, benztropine, butalbital-apap,butalbital-apap-caffeine,butalbital-asa-caffeine, carisoprodol, chlordiazepoxide-amitriptyline, chlorzoxazone, , clomipramine, cyclobenzaprine, cyprohepatadine, desipramine, dicyclomine, digoxin, , dipyridamole, doxepin, entacapone, ergoloid mesylate, estrogen esterified, estrogen oral and patches, estropipiate, eszopiclone, FYAVOLV, glyburide micronized, glyburide, glyburide-metformin, guanfacine ER, guanfacine, hydroxyzine, imipramine, indomethacin, INTUNIV, JINETILI, ketorolac tromethamine, LANOXIN, LOPREEZA, megestrol, MENEST, meprobamate, methocarbamol, methyldopa, methyldopa-hctz, MIMVEY, NORPACE CR, nifedipine, northindrone-ethyenyl estradiol, nortriptyline, orphenadrine citrate ER, methocarbamol, , pentazocine-naloxone, perphenazine-amitriptyline, PHENERGAN, phenobarbital tab/elixir, PREMARIN, PREMPRO, promethazine, promethegan, protriptyline, , TENCON, thioridazine, trihexyphenidyl, trimethobenzamide, trimipramine, VANATOL LQ, zaleplon, ZEBUTAL, zolpidem ER, zolpidem

- The prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication. ☐ Yes ☐ No

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Rationale for Request (Required)	
☐ Alternate drug(s) contraindicated or previously tried but with adverse outcome (e.g., toxicity, allergy, or therapeutic failure). Specify below: 1. Document drug(s) contraindicated or tried: 2. Adverse outcome for each drug: 3. If therapeutic failure, length of therapy on each drug(s):	☐ Medical need for different dosage form and/or higher dosage. Specify below: 1. Dosage form(s) and/or dosage(s) tried: 2. Explain medical reason:
☐ Patient is stable on current drug(s); high risk of significant adverse clinical outcome or decompensation with medication change. Specify below: 1. Anticipated significant adverse clinical outcome (explain in detail):	☐ Request for formulary tier exception. Specify below: 1. Formulary or preferred drugs contraindicated or tried and failed, or tried and not as effective as requested drug: 2. If therapeutic failure, length of therapy on each drug and adverse outcome: 3. If not as effective, length of therapy on each drug and outcome:
☐ Other (explain in detail):	

Prescriber Signature or Authorized Representative signature ***Date***

Web Link for PA Form: https://medicare.magellanrx.com/provider/forms
Email this form to: MRxMedicarePrtDClnOP@magellanhealth.com
Fax This Form to: 1-800-424-5872
Call us at: 1-800.424.5870

Mail this form to
MagellanRx Medicare
P.O. Box 1433
St Louis, MO 63043