Print Reset

Alaska Medicaid

General Prior Authorization Form

Magellan Rx MANAGEMENT

Fax this form to (888) 603-7696

Form available on Alaska Medicaid's Medication Prior Authorization website

This form may also be used for requests to exceed the maximum allowed units.

This authorization request does not ensure eligibility and is not a guarantee of payment. Please verify Medicaid eligibility before completing this form. Incomplete requests will be denied until all required information is received.

Request Date: _____

REQUESTOR INFORMATION

Requestor Name: _____ Title: _____

MEMBER INFORMATION

Last Name: _____ First Name: _____

Member ID #: _____ Date of Birth: _____

Sex: ☐ Male ☐ Female Member Phone: _____

PRESCRIBER INFORMATION

Last Name: _____ First Name: _____

Prescriber NPI: _____ Specialty: _____

Prescriber Phone: _____ Prescriber Fax: _____

PHARMACY INFORMATION

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone: _____ Pharmacy Fax: _____

DRUG INFORMATION

Drug Name: _____ NDC: _____

Drug Strength: _____ Dosage Form: _____

Dosage Schedule: _____ Quantity: _____ Day Supply: _____

Is this a physician-administered drug? ☐ Yes ☐ No

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Last Name: _____ First Name: _____

CLINICAL INFORMATION

1. Primary Diagnosis:

2. Other Diagnoses:

3. Current Medications:

4. Medical Justification (including previous failed therapies with dates):

☐ Attachments

Attestation: I hereby certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by Alaska Medicaid.

Prescriber Signature: _____ **Date:** _____
(required)

Magellan Medicaid Administration, PA Unit
14100 Magellan Plaza
Maryland Heights, MO 63043
Phone: (800) 331-4475

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