Print Reset

Alaska Medicaid

Patient Readiness Assessment Attestation

Magellan Rx MANAGEMENT

Fax this form to (888) 603-7696

Please file signed version in patient chart and provide copy to patient; fax copy to Magellan Medicaid with Prior Authorization request. Please allow **three days** for prior authorization processing.

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: _____

PROVIDER CHECKLIST

- ☐ The patient has been evaluated for readiness to treat, which includes identification of potential impediments to successful therapy (e.g., compliance difficulty, missed appointments, inadequate social support, or sub-therapeutic management of comorbid mental health conditions).
- ☐ If an impediment was identified, the patient has been connected with services to assist patient with identified challenge.
- ☐ The patient has a history of alcohol misuse.
- ☐ The patient agrees to abstain from alcohol use during treatment.
- ☐ I would like to refer the patient to the Alaska Medicaid Coordinated Care Initiative Provider Program to help connect her/him to additional resources.

Alaska Medicaid Patient Readiness Assessment Attestation

Last Name: _____ First Name: _____

PATIENT CHECKLIST

- ☐ I understand that the use of alcohol can hurt my liver both during and after treatment for the hepatitis C virus.
- ☐ I know where to find help for my questions about alcohol use and misuse.
- ☐ I understand that misusing opioids and other drugs can hurt my liver both during and after treatment for the hepatitis C virus.
- ☐ I understand that there are certain activities that increase my risk of re-infection with the hepatitis C virus.
- ☐ I would like someone from the Alaska Medicaid Coordinated Care Initiative Member Program to call me to help connect me to resources or help answer questions I have.

Treatment Start Date: _____

Treatment End Date: _____

Number of Weeks: _____

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

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

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

Fax this form to (888) 603-7696