Print Reset

Alliant Health Prior Authorization Request Prescriber Fax
Step Therapy
Fax this form to 800-424-4054 **A fax cover sheet is not required.**

Magellan Rx partners with CoverMyMeds to allow for the submission of electronic PA requests. **For faster coverage determinations, go to www.CoverMyMeds.com.**

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews. Incomplete forms will be returned for additional information. The following documentation is required for preauthorization consideration. For formulary information visit https://magellanrx.com.

What is the priority level of this request?

- ☐ Standard
- ☐ Date of service (if applicable): _____
- ☐ Urgent (**Note**: Urgent is defined as when the prescriber believes that waiting for a standard review could seriously harm the patient's life, health, or ability to regain maximum function.)

Today's Date: _____

PATIENT INFORMATION

Patient Last Name: _____

Patient First Name: _____

Patient ID: _____ Date of Birth: _____ Patient Phone: _____

Patient Street Address: _____

City: _____ State: _____ Zip: _____

Sex: ☐ Male ☐ Female Height: _____ ☐ in. ☐ cm Weight: _____ ☐ lbs. ☐ kg

Allergies: _____

PRESCRIBER INFORMATION

Prescriber Last Name: _____

Prescriber First Name: _____

Specialty: _____ Email: _____

Prescriber NPI: _____ DEA: _____

Prescriber Phone: _____ Prescriber Fax: _____

Prescriber Street Address: _____

City: _____ State: _____ Zip: _____

Patient's Name (Last, First): _____

DRUG INFORMATION

Drug Name: _____ Drug Form: _____

Drug Strength: _____ Dosing Frequency: _____

Length of Therapy: _____ Quantity: _____

Number of Refills: _____ Day Supply: _____

☐ New Therapy ☐ Renewal If renewal, date therapy initiated: _____

If renewal, duration of therapy (specific dates): _____ to _____

CRITERIA (CONTINUED)

Note: Please attach any additional information that should be considered with this request.

Patient Diagnosis: _____

ICD (Code):_____

ICD Description: _____

1. Is the patient currently being treated with the requested agent?
   ☐ Yes ☐ No

   If Yes, when was treatment with the requested medication started? _____

   If Yes, was the patient started on samples?
   ☐ Yes ☐ No

   If Yes, is the patient at risk if therapy is changed?
   ☐ Yes ☐ No

   If Yes, please explain: _____

2. Please list all other medications the patient will use in combination with the requested medication for the treatment of this diagnosis.

   _____

3. Please list all reasons for selecting the requested medication, strength, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA maximums).

   _____

Patient's Name (Last, First): _____

CRITERIA (CONTINUED)

4. Please list all medications that the patient has previously tried and failed for treatment of this diagnosis. (Please specify whether the patient has tried brand-name products, generic products, or over-the-counter products.)

   Medication: _____ Type: _____

   Date (from): _____ Date (to): _____

   Medication: _____ Type: _____

   Date (from): _____ Date (to): _____

   Medication: _____ Type: _____

   Date (from): _____ Date (to): _____

For behavioral health diagnoses:

5. Please list all reasons for selecting the requested medication over alternatives (e.g., contraindications, risk with change, started on while in hospital, allergies or history of adverse drug reactions, lower dose).

☐ Attachments

ATTESTATION

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group, 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's Signature: _____ **Date:** _____

(By signature, the physician confirms the above information is accurate and verifiable by patient records.)

Please fax or mail this form to:

Magellan Rx Management, LLC
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811
Phone: 1-800-424-3312

Fax this form to 800-424-3260