UPHP HEALTH PLAN REQUEST FOR PRIOR AUTHORIZATION

(ALL AUTHORIZATIONS ARE PENDING VALID ELIGIBILITY)

PRESCRIBING PHYSICIAN:

Name:_____
First **Last**

Direct Phone #: (_ _ _) - _ _ _ - _ _ _ _

Fax #: (_ _ _) - _ _ _ - _ _ _ _

Physician specialty: _____

BENEFICIARY:

Name:_____
First **Last**

Medicaid ID #: _____

Date of Birth: _ _ - _ _- _ _ _ _

Sex: ☐ **Female** ☐ **Male**

Name and title of person completing form (please print): _____

Drug name: **Strength:** **Administration Schedule:** **Length of Therapy:** **Quantity Requested:**

a) _____

b) _____

c) _____

Patient's diagnosis for use of this medication: _____

1. **Previous history of a medical condition, allergies or other pertinent medical information, that necessitates the use of this medication:**
   _____

2. **Has the patient been seen by any other provider for this condition?** ■ **Yes** ■ **No**
   If so, what was the prescriber's specialty? _____

3. **Previous non-prior authorized and prior authorized medications tried and failed for this condition:**

Name of medication	Reason for failure	Date:
		_ _/_ _/_ _ _ _
		_ _/_ _/_ _ _ _
		_ _/_ _/_ _ _ _

4. **Pertinent laboratory test or procedure: (if applicable)**

Procedure:	Findings:	Date:
		_ _/_ _/_ _ _ _
		_ _/_ _/_ _ _ _
		_ _/_ _/_ _ _ _

5. **Other Information:**
   _____
   _____
   _____

Submit Requests to:
MagellanRx ManagementSystems
2520 Industrial Row Drive
Troy, MI 48084
Phone: (248) 540-6686 Fax: (248) 341-8133

MRx PA COMMENTS:_____

DT REC:_____ TIME REC:_____
GCN: a)_____ b)_____ c)_____
EC: a)_____ b)_____ c)_____
Qty:a)_____ b)_____ c)_____
Appd :a)_____ b)_____ c)_____
R.Ph:_____ DATE:_____
Entrd by: _____ DATE:_____
Auth # a)_____
b)_____
c)_____