UPHP HEALTH PLAN REQUEST FOR PRIOR AUTHORIZATION

(ALL AUTHORIZATIONS ARE PENDING VALID ELIGIBILITY)

UPHP
UPPER PENINSULA HEALTH PLAN

DATE OF REQUEST:_____
MM/DD/YY

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: _____

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	Dates:

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

Procedure:	Findings:	Date:

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

MRx PA COMMENTS:_____

Submit Requests to:
Magellan Rx Management
PO Box 2187
Maryland Heights, MO 63043
Phone: (888) 274-2031 Fax: (888) 656-3604

Updated November 2021