UPHP Health Plan Request for Prior Authorization

(ALL AUTHORIZATIONS ARE PENDING VALID ELIGIBILITY)

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, LLC
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811
Phone: 888-274-2031 Fax: 888-656-3604

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