

**Prior Authorization Request Form
For Atypical Antipsychotic Agents only
Kentucky Medicaid**

Mental Health Drug

Fax this signed, completed form to: (800) 365-8835

Questions? Call Magellan Medicaid Administration at (800) 477-3071

Note: ** For approvable ICD – 9 diagnosis codes, refer to website <https://kentucky.magellanmedicaid.com>

"Pharmacy Provider Notice #128 – 5/6/2011"

Revised 11/14/11

REQUESTOR	<input type="checkbox"/> Prescriber <input type="checkbox"/> Pharmacy	Requestor Name <i>(Print)</i>
RECIPIENT	Last Name, First Name, Middle I.:	
DOB:	Recipient ID:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
PRESCRIBER	Name:	NPI: - - - - -
Phone: ()		Fax: ()
Specialty:		
PHARMACY	Name:	NPI: - - - - -
Phone: ()		Fax: ()
REQUEST	Drug:	Strength: Dosage Form:
Primary Diagnosis:**	Dosage schedule:	
Other Diagnoses:	QTY:	Day Supply:
RATIONALE FOR PRIOR AUTHORIZATION	Requested Start Date: / /	

If requesting multiple atypical antipsychotic agents, please provide clinical rationale.

PREVIOUS THERAPY (List of pertinent information regarding all drugs previously or currently used for this diagnosis as reflected by documentation in physician's chart or recent hospitalization)	DOSAGE FORM	STRENGTH	DIRECTIONS FOR USE	DATE TREATMENT STARTED or date when hospitalized	DATE TREATMENT ENDED or date discharged from hospital

PATIENT RECENTLY HOSPITALIZED If checked, please provide hospitalization dates and discharge dosages of Atypical Antipsychotic medications in table above.

Signature of submitter _____ Date: _____
 By signing this form, the prescriber is attesting that documentation supporting the above information is recorded in the Patient's Medical Chart.

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