

Kentucky Medicaid

Drug Prior Authorization Request Form

Not to be used for Atypical Antipsychotic Agents, Buprenorphine Products, Zyvox, or Brand Name PA Requests

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

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

Note: One drug request per fax form please.

Reformatted 6/28/11

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

CURRENT MEDICATIONS

MEDICAL JUSTIFICATION (including drugs already tried-provide dates)

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.

This authorization request is not a guarantee of payment. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program.

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