

Alaska Medicaid Prior Authorization Form [General]

Fax this request to: 1-888-603-7696

Questions: Call Magellan Medicaid Administration at 800-331-4475

Or mail this request to: Medicaid PA Unit, 14100 Magellan Plaza, Maryland Heights, MO 63043

Note: This authorization request does not ensure eligibility and is not a guarantee of payment. Please verify Medicaid eligibility before submitting this form. 06/2015

If the following information is not complete, correct, or legible, the PA process can be delayed. Use one form per member please.

Form available at: <http://dhss.alaska.gov/dhcs/Pages/pharmacy/medpriorauthoriz.aspx>**Member Information**

LAST NAME:

FIRST NAME:

ID NUMBER:

DATE OF BIRTH:

 - -

GENDER

 M F**Prescriber Information**

LAST NAME:

FIRST NAME:

NPI NUMBER:

SPECIALTY:

PHONE NUMBER:

 - -

FAX NUMBER:

 - - **Pharmacy Information**

NAME:

NPI NUMBER:

PHONE NUMBER:

 - -

FAX NUMBER:

 - - **INSTRUCTIONS TO THE PROVIDER:**

Drug: _____ Strength: _____ Dosage Form: _____

Dosage Schedule: _____ Primary Diagnosis: _____

Qty: _____ Day Supply: _____ Other Diagnoses: _____

Requested Prior Authorization Start Date _____ Current Medication List (or, see attached): _____ when approved, or / / **Medical Justification** (additional documentation may be attached when needed to support request)

 Letter of Medical Necessity attached, when required Previously failed therapies with inclusive trial dates, when required (may attach additional documentation)**Prescriber Signature (Required)****Date**

(By signature, the Prescriber confirms the above information is accurate and verifiable by patient records.)

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