

Pharmacy – Miscellaneous

Maximum length of approval = 12 months or less

pust be completed in full. An incomplete form may

	Note: Form must be completed in full. An incomplete form may be returned.																										
Recipient's Medicaid ID# Date of Birth (MM/DD/YYYY)																											
												/			/												
Recipient's Full Name																											
Prescribe	r's Full N	lame																									
Prescribe	r License	e # (N	IE, O	S, Al	RNP,	PA)							,		1									•			
Prescribe	Prescriber Phone Number Pres													escriber Fax Number													
					-																		-				
Drug: _	Quantity: Dosage and Frequency of Dosing:																										
Diagnos	Diagnosis:																										
Previous Therapy (include drug, dose, and duration):																											
											-						Da	te of	trial	l:							
	1																										
	3																										
	Reason for Discontinuing Previous Therapy:																										
Allergic reaction (please specify and submit progress notes to support):																											
Contraindication(s) (list conditions):																											
	Drug interaction(s) (please specify): Therapeutic Failure (please provide lab data, discharge summaries, or progress notes):																										
	Therape	eutic I	-ailu	re (p	leas	se pr	ovid	le la	b da	ata,	disc	har	ge s	umn	narie	es, o	r pro	ogre	ss n	otes	s): _					_	
Medical	Medical records supporting requested therapy over other preferred medications listed on the Florida Medicaid																										
Preferre	d Drug	List	are	requ	ired	. Thi	s list	may	/ be	fou	nd a	t <u>htt</u>	o://al	hca.r	nyflo	orida	.com	n/Me	dica	id/P	resc	ribed	Dru	ıg/pl	narm	_the	<u>:ra/</u> .
Prescrib	er's Si	gnatı	ıre														Date	:									
REQUIRE	ED FOR	REVI	EW:				ical re	ecord	ds (i.	e., d	iagn	ostic	evalı	uation	ns an	d red	ent o	chart	note	s), a	copy	of th	e ori	ginal	pres	cripti	on,
and the m	iost rece	III CO	nes (or rela	atea	iads.																					

The provider must retain copies of all documentation for five years.

Mail or Fax Information to:

Magellan Medicaid Administration, Inc. Prior Authorization

P. O. Box 7082

Tallahassee, FL 32314-7082 Phone: 877-553-7481 Fax: 877-614-1078