



FLORIDA MEDICAID PRIOR AUTHORIZATION

Pharmacy – Miscellaneous

Maximum length of approval = 12 months or less

Note: Form must be completed in full. An incomplete form may be returned.

Recipient's Medicaid ID#

Grid for Recipient's Medicaid ID#

Date of Birth (MM/DD/YYYY)

Grid for Date of Birth

Recipient's Full Name

Grid for Recipient's Full Name

Prescriber's Full Name

Grid for Prescriber's Full Name

Prescriber's NPI

Grid for Prescriber's NPI

Prescriber Phone Number

Grid for Prescriber Phone Number

Prescriber Fax Number

Grid for Prescriber Fax Number

Drug: _____ Quantity: _____ Dosage and Frequency of Dosing: _____

Diagnosis: _____

Previous Therapy (include drug, dose, and duration):

- 1. _____ Date of trial: _____
2. _____ Date of trial: _____
3. _____ Date of trial: _____

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): _____

Medical records supporting requested therapy over other preferred medications listed on the Florida Medicaid Preferred Drug List are required. This list may be found at http://ahca.myflorida.com/Medicaid/Prescribed_Drug/pharm_thera/.

Empty box for medical records supporting requested therapy

Prescriber's Signature _____ Date: _____

REQUIRED FOR REVIEW: Copies of medical records (i.e., diagnostic evaluations and recent chart notes), a copy of the original prescription, and the most recent copies of related labs.

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

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