



Prescription Drug Prior Authorization Request Form

MEMBER INFORMATION

LAST NAME:

FIRST NAME:

MEMBER ID NUMBER:

WEIGHT (CHECK ONE UNIT OF MEASUREMENT):

kg OR lbs

DATE OF BIRTH:

PRESCRIBER INFORMATION

LAST NAME:

FIRST NAME:

NPI NUMBER:

PRESCRIBER'S OFFICE STAFF MEMBER COMPLETING FORM:

PHONE NUMBER:

FAX NUMBER:

PHARMACY INFORMATION (IF AVAILABLE)

PHARMACY PROVIDER

PHARMACY'S PHONE NUMBER:

PHARMACY'S FAX NUMBER:

Drug Name	Strength	Directions for Use	Diagnosis

PREVIOUS MEDICATIONS (PLEASE INCLUDE DATES AND OUTCOME) AND OTHER MEDICAL JUSTIFICATION FOR USE:

Prescriber's Signature (Required)

Date

Prescriber Specialty

Fax this request to: 1-888-272-1349

Questions? Please call 1-800-651-8921 or visit us at: <https://gatorcare.magellanrx.com/>

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