This request is being submitted for the following

Drug Name: ___________________________  Strength: ___________________________  Administration Schedule: ___________________________

Please provide patient-specific information which supports the medical necessity of the requested medication as opposed to another currently available covered alternative.

1. Diagnosis related to use: ___________________________

2. Expected duration of therapy: ___________________________

3. Alternative medications tried for this diagnosis:
   Drug: ___________________________  Dose: ___________________________  Date: ___________________________  Outcome: ___________________________
   Drug: ___________________________  Dose: ___________________________  Date: ___________________________  Outcome: ___________________________
   Drug: ___________________________  Dose: ___________________________  Date: ___________________________  Outcome: ___________________________

4. Patient’s Weight: ___________________________  Patient’s Height: ___________________________

5. Additional pertinent information: (please include clinical reasons for drug, relevant lab values, etc.):
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

Prescriber Signature: ___________________________  Date: ___________________________
(With this signature, the prescriber confirms that the information above is accurate and verifiable in patient records.)
Please note: The Department may request chart documentation to verify the above information.

Submit requests to: Magellan Medicaid Administration, Inc.  Fax 1-866-759-4115  Tel 1-800-241-8335