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MAGELLAN COMPLETE CARE

Prior Authorization

Botox®

Medicaid coverage is approved for children being treated by the Shriner's clinic only.
All other botulinum products are covered through physician services. This form is not required for reimbursement through physician services.
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

Prescriber's Full Name

Prescriber License # (ME, OS, ARNP, PA)

Prescriber Phone Number ___ - ____

Prescriber Fax Number ___ - ____

Pharmacy Name

Pharmacy Medicaid Provider #

Pharmacy Phone Number ___ - ____

Pharmacy Fax Number ___ - ____

1. Is the patient receiving Botox therapy at Shriner's Clinic? ○ Yes ○ No

2. What is the recipient's diagnosis? _____

3. What will be the dosage and frequency of dosing? _____

4. Requested date of therapy (MM/DD/YYYY): _____

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.**

Magellan Complete Care

MCC Physician Review: ○ I do not recommend Approval. ○ I recommend Approval for _____ months.

MCC Physician Signature: _____ **Date:** _____

Fax or mail completed forms to:

Magellan Complete Care
c/o Magellan Pharmacy Solutions
11013 West Broad Street, Suite 500
Glen Allen, VA 23060

Phone: 1-800-327-8613
TTY: 1-800-424-1694
Fax: 1-800-424-7982

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