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MAGELLAN COMPLETE CARE

Prior Authorization

Oral Oncology Agents

Maximum Length of Approval = One Year

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 ___ - ____

Provider Speciality: _____

Medication Request: ◯ **New** ◯ **Continuation**

Height: _____ in _____ cm **Weight**: _____ lbs _____ kgs **BMI %**: _____

1. Medication Requested:

Medication	Strength	Directions	# of Cycles	Quantity/Month

2. Diagnosis:

☐ Breast Cancer ☐ Renal Cancer ☐ Prostate Cancer ☐ Lung Cancer ☐ Ovarian Cancer

☐ Leukemia ☐ Other Diagnosis: _____

3. Previous Medication Trials:

Medication	Strength	Directions	Start/End Dates	Maximum Dose (Per Day)
			Start: End:	
			Start: End:	

4. List all other medications the patient is taking concurrently with the antineoplastic:

Medication	Strength	Directions	# of Cycles

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.**

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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