

MAGELLAN COMPLETE CARE

Prior Authorization
Supprelin® LA (Histrelin Acetate)
Maximum Length of Therapy = Date of Service

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 (MM/DD/YYYY)

Recipient's Full Name

Grid for Recipient's Full Name

Prescriber's Full Name

Grid for Prescriber's Full Name

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

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

Prescriber Phone Number

Grid for Prescriber Phone Number

Prescriber Fax Number

Grid for Prescriber Fax Number

Prescriber Specialty

Line for Prescriber Specialty

1. Is this medication for precocious puberty?

Yes No

If Yes, specify ICD: _____

2. Is the prescriber a pediatric endocrinologist?

Yes No

3. Has the patient had a clinical course of either Lupron® Depot-Ped or Synarel® that has failed or was not tolerated (within the last six months)?

Yes No

Note: Legible copies of progress notes describing these events are required, please attach.

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

