Print Reset

Alliant Health Prior Authorization Request Prescriber Fax
Quantity Exception

Fax this form to 800-424-4054 **A fax cover sheet is not required.**

Magellan Rx partners with CoverMyMeds to allow for the submission of electronic PA requests. **For faster coverage determinations, go to www.CoverMyMeds.com.**

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews. Incomplete forms will be returned for additional information. The following documentation is required for preauthorization consideration. For formulary information visit https://magellanrx.com.

What is the priority level of this request?

- ☐ Standard
- ☐ Date of service (if applicable): _____
- ☐ Urgent (**Note**: Urgent is defined as when the prescriber believes that waiting for a standard review could seriously harm the patient's life, health, or ability to regain maximum function.)

Today's Date: _____

PATIENT INFORMATION

Patient Last Name: _____

Patient First Name: _____

Patient ID: _____ Date of Birth: _____ Patient Phone: _____

Patient Street Address: _____

City: _____ State: _____ Zip: _____

Sex: ☐ Male ☐ Female Height: _____ ☐ in. ☐ cm Weight: _____ ☐ lbs. ☐ kg

Allergies: _____

PRESCRIBER INFORMATION

Prescriber Last Name: _____

Prescriber First Name: _____

Specialty: _____ Email: _____

Prescriber NPI: _____ DEA: _____

Prescriber Phone: _____ Prescriber Fax: _____

Prescriber Street Address: _____

City: _____ State: _____ Zip: _____

Patient's Name (Last, First): _____

DRUG INFORMATION

Drug Name: _____ Drug Form: _____

Drug Strength: _____ Dosing Frequency: _____

Length of Therapy: _____ Quantity: _____

Number of Refills: _____ Day Supply: _____

☐ New Therapy ☐ Renewal If renewal, date therapy initiated: _____

If renewal, duration of therapy (specific dates): _____ to _____

CRITERIA

Note: Please attach any additional information that should be considered with this request.

Patient Diagnosis: _____

ICD Code: _____

ICD Description: _____

1. Is the patient currently being treated with the requested agent?
   ☐ Yes ☐ No
2. What is the patient's weight? _____
3. What is the patient's body surface area (BSA) in square meters (m^2)? _____
4. Please list all reasons for selecting the requested medication, strength, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA maximum).

   _____

5. Please list all medications that the patient has previously tried and failed for treatment of this diagnosis. (Please specify whether the patient has tried brand-name products, generic products, or over-the-counter products.)

   Medication: _____ Type: _____

   Date (from): _____ Date (to): _____

   Medication: _____ Type: _____

   Date (from): _____ Date (to): _____

   Medication: _____ Type: _____

   Date (from): _____ Date (to): _____

Patient's Name (Last, First): _____

CRITERIA (CONTINUED)

For Alinia (nitazoxanide):

6. Does the patient have a diagnosis of diarrhea caused by Giardia lamblia or Cryptosporidium parvum?
   ☐ Yes ☐ No
7. Is the patient an adult with a diagnosis of Fasciola infection?
   ☐ Yes ☐ No
8. Does the patient have a diagnosis of general intestinal parasitism?
   ☐ Yes ☐ No

For anticoagulant agents:

9. Has the patient been re-infected and requires an additional course of therapy?
   ☐ Yes ☐ No
10. Will the requested agent be used for prophylaxis of deep vein thrombosis (DVT) and pulmonary embolism (PE) following hip replacement surgery?
    ☐ Yes ☐ No
11. Will the requested agent be used for prophylaxis of DVT and PE following knee replacement surgery?
    ☐ Yes ☐ No
12. Will the requested agent be used for treatment of DVT/PE?
    ☐ Yes ☐ No
13. Will the requested agent be used to reduce the risk of recurrence of DVT/PE?
    ☐ Yes ☐ No

    If Yes, has the patient completed initial treatment lasting at least 6 months?
    ☐ Yes ☐ No
14. Will the requested agent be used to reduce the risk of stroke and systemic embolism in patients with nonvalvular atrial fibrillation?
    ☐ Yes ☐ No
15. Will the requested agent be used to reduce the risk major cardiovascular (CV) events (CV death, myocardial infarction [MI], and stroke) in chronic coronary artery disease (CAD) or peripheral artery disease (PAD)?
    ☐ Yes ☐ No

For antiemetic agents:

16. Does the patient have delayed emesis in highly emetogenic chemotherapy?
    ☐ Yes ☐ No

    If Yes, how many days per month is the patient receiving chemotherapy? _____Days

Patient's Name (Last, First): _____

CRITERIA (CONTINUED)

If Yes, will the requested agent be used in addition to the patient's current regimen?

☐ Yes ☐ No

17. Does the patient have a diagnosis of hyperemesis gravidarum?

☐ Yes ☐ No

18. Does the patient have radiation therapy induced nausea and vomiting that extends beyond 7 days per month?

☐ Yes ☐ No

19. For Cesamet™, has the patient tried and had an inadequate response to one conventional antiemetic agent (e.g., granisetron, ondansetron, Akynzeo®, Anzemet®, Emend®, Varubi®)?

☐ Yes ☐ No

For anti-influenza agents:

20. Does the patient require additional courses of therapy due to additional episodes of acute influenza infection?

☐ Yes ☐ No

21. Does the patient require additional courses or increased duration of therapy for prophylaxis after exposure to an influenza infected person?

☐ Yes ☐ No

22. Is there a shortage of the requested agent?

☐ Yes ☐ No

For armodafinil and modafinil agents:

23. Will the patient be receiving only one strength of only one agent at a time?

☐ Yes ☐ No

For buprenorphine and buprenorphine/naloxone:

24. Has the prescriber met the qualification certification criteria in the Drug Addiction Treatment Act (DATA) of 2000 and been issued a unique DEA identification number by the DEA, indicating that he or she is a qualified physician under DATA to prescribe Subutex®/Suboxone®/Zubsolv®?

☐ Yes ☐ No

25. For Subutex®, is the patient pregnant?

☐ Yes ☐ No

26. For Subutex®, does the patient have a documented intolerance, FDA-labeled contraindication, or hypersensitivity to naloxone or naltrexone?

☐ Yes ☐ No

If Yes, please explain: _____

Patient's Name (Last, First): _____

CRITERIA (CONTINUED)

For Cablivi®:

27. Has the patient had at least one occurrence of acquired thrombotic thrombocytopenic purpura (aTTP) during the current course of therapy?

    ☐ Yes ☐ No

    If Yes, has the patient had more than 2 occurrences of aTTP while using the requested agent during the current course of therapy?

    ☐ Yes ☐ No

    If No, has the patient had a relapse or recurrence of aTTP after completion of a course of therapy and requires an additional course of therapy?

    ☐ Yes ☐ No

For low molecular weight heparins (LMWH) and Arixtra®:

28. Does the patient require extended treatment for primary or secondary prophylaxis of thromboembolism during pregnancy and/or puerperium?

    ☐ Yes ☐ No

29. Does the patient have cancer and require extended prophylaxis and/or treatment of symptomatic VTE (proximal DVT and/or PE)?

    ☐ Yes ☐ No

For ophthalmic prostaglandins:

30. Is product wastage significant but unable to be avoided (i.e., the patient or care giver is not able to properly instill eye drops without excess wastage)?

    ☐ Yes ☐ No

For opioid immediate-release (IR) agents:

31. Does the patient have a diagnosis of cancer?

    ☐ Yes ☐ No

32. Is the patient enrolled in hospice care?

    ☐ Yes ☐ No

33. Is the patient receiving palliative care?

    ☐ Yes ☐ No

34. Will the requested opioid be used for post-operative pain management following a tonsillectomy and/or adenoidectomy?

    ☐ Yes ☐ No

For Prevymis™:

35. Has the patient had an additional allogenic hematopoietic stem cell transplant (HSCT) and requires initiation of Prevymis™?

    ☐ Yes ☐ No

Patient's Name (Last, First): _____

CRITERIA (CONTINUED)

For proton-pump inhibitors (PPI):

36. Does the patient have a hypersecretory disease (i.e., Zollinger-Ellison syndrome), Barrett's esophagitis, or esophageal stricture?
    ☐ Yes ☐ No
37. Has the patient failed conventional therapy (i.e., failure of standard labeled dosing with the requested agent)?
    ☐ Yes ☐ No
38. Is the patient requesting H. pylori treatment?
    ☐ Yes ☐ No

For Rho Kinase inhibitors:

39. Is product wastage significant but unable to be avoided (i.e., the patient or care giver is not able to properly instill eye drops without excess wastage)?
    ☐ Yes ☐ No

For Samsca®:

40. Has the patient had an additional hospitalization for hyponatremia and for initiation of Samsca®?
    ☐ Yes ☐ No

For triptans (such as Imitrex®):

41. Does the patient have a diagnosis of migraine headache?
    ☐ Yes ☐ No

    If Yes, is the patient currently using migraine prophylactic medication (i.e., anticonvulsants [i.e., divalproex, valproate, topiramate], beta blockers [i.e., atenolol, metoprolol, nadolol, propranolol, timolol], antidepressants [i.e., amitriptyline, venlafaxine])?
    ☐ Yes ☐ No

    If No, does the patient have a documented intolerance, FDA-labeled contraindication, or hypersensitivity to an anticonvulsant, a beta blocker, and an antidepressant listed above)?
    ☐ Yes ☐ No

    If Yes, please explain:

    _____

42. Has the patient been evaluated for medication overuse headache?
    ☐ Yes ☐ No

    If Yes, has it been found that patient does have medication overuse headache?
    ☐ Yes ☐ No

Patient's Name (Last, First): _____

☐ Attachments

ATTESTATION

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group, or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber's Signature: _____ **Date:** _____

(By signature, the physician confirms the above information is accurate and verifiable by patient records.)

Please fax or mail this form to:

Magellan Rx Management, LLC

Attn: CP – 4201

P.O. Box 64811

St. Paul, MN 55164-0811

Phone: 1-800-424-3312

Fax this form to 800-424-3260