

If the following information is not complete, correct, or legible, the SA process can be delayed.

Please use one form per member.

**MEMBER INFORMATION**

Member's Last Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Member's First Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

MCC VA ID Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Date of Birth:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Gender:  Male  Female

Weight in Kilograms: \_\_\_\_\_

**PRESCRIBER INFORMATION**

Prescriber's Last Name:

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Prescriber's First Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

NPI Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Specialty:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Phone Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Fax Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Street Address:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

City:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

State:

--	--	--	--

Zip Code:

--	--	--	--	--	--	--	--

**DRUG INFORMATION**

Drug Name: \_\_\_\_\_

Strength: \_\_\_\_\_

Directions for Use: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

(Form continued on next page.)

Member's Last Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Member's First Name:

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**DRUG INFORMATION (Continued)**

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Date member started medication (if previously started): \_\_\_\_\_

Name of specific medication(s) tried and failed: \_\_\_\_\_

Reason for non-formulary request, and/or clinical justification for requested drug use (Please include relevant lab values when appropriate. **Note:** Member chart notes will be requested if further documentation is necessary): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Additional notes: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Prescriber Signature (Required)**

**Date**

*By signature, the Physician confirms the above information is accurate and verifiable by member records.*

**Please include ALL requested information; Incomplete forms will delay the SA process.** Submission of documentation does NOT guarantee coverage by Magellan Complete Care of Virginia.

The completed form may be **FAXED TO 1-800-922-3986** or mailed to:

Magellan Rx Management Prior Authorization Program  
c/o Magellan Health, Inc.  
11013 West Broad Street  
Glen Allen, VA 23060

**Phone:** 1-800-424-4524 (TTY 711)