# Arkansas Medicaid Prescription Drug Program Statement of Medical Necessity
# Prior Authorization Request

**After completing the information below please fax to the Arkansas Medicaid Pharmacy Program. Fax: 1-800-424-7976. For questions call: 1-800-424-7895.**

Requestor Name and Title: _____

**If the following information is not complete, correct, or legible, the PA process can be delayed.** Use one form per beneficiary please.

***Beneficiary Information***

**LAST NAME:** | **FIRST NAME:**

**MEDICAID ID NUMBER:** | **DATE OF BIRTH:** ___ – ___ – ____

**PHARMACY FAX NUMBER (IF KNOWN)** ___ – ___ – ____

***Prescriber Information***

**LAST NAME:** | **FIRST NAME:**

**NPI NUMBER:** | **DEA NUMBER:**

**PHONE NUMBER:** ___ – ___ – ____ | **FAX NUMBER:** ___ – ___ – ____

**MEDICATION REQUESTED* (PLEASE LIST DRUG AND STRENGTH):**

***Please note that if the requested medication is for Hepatitis C treatment, Selzentry®, Suboxone®/Subutex®, Synagis®, Xolair®, or Invega Trinza®, please complete the appropriate prior authorization request, Medically Necessary (Medwatch), and Informed Consent forms that can be found at https://arkansas.magellanrx.com -> Provider -> Resources -> Forms**

**MEDICATION:** _____ **STRENGTH:** _____

**DIAGNOSIS:**

**Please attach or include a letter of Medical Necessity along with supporting documentation (e.g. chart notes, lab results, etc.) to assist in the prior authorization process and fax to Magellan Arkansas Medicaid Pharmacy Unit at 800-424-7976.**

_____ _____

***Prescriber Signature (Required)*** | ***Date***

***Prescriber's original signature required; copied, stamped, or e-signature are not allowed.***

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

Please retain this documentation in the patient's medical records. Falsification of medical records is liable to the United States Government for a civil penalty of not less than $5,000 and not more the $10,000, plus 3 times the amount of damages which the Government sustains because of the act of that person. (42 U.S.C.A. § 3729(a)) Confidentiality Notice: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender (Via return FAX) immediately and arrange for the return or destruction of these documents.