TN Division of Health Care Finance & Administration | TennCare

Prior Authorization Form
General/Non-Preferred Drugs

Access this PA form at https://tenncare.magellanhealth.com/static/docs/Prior_Authorization_Forms/TennCare_General_PA_Request_Form.pdf

Drug/class-specific PA forms must be used whenever available, including:

Antidepressants: SNRIs	Diabetic Supplies	Long Acting Narcotics	Sovaldi
Atypical Antipsychotics	Dipeptidyl-Peptidase IV Inhibitors	Olysio	Synagis
Benzodiazepines	Growth Hormones	Ophthalmic NSAIDs	Technivie
Beta Agonist Combination Products	Harvoni	PPIs	Thiazolidinediones
Buprenorphine Products	High Potency Statins	Promethazine (Age < 2 Years Old)	Topical Immunomodulators
Celebrex	Incretin Mimetics	Provigil/Nuvigil	Viekira
Compounds	Influenza Antivirals	Schedule II Stimulants	
Daklinza	I/DD Worksheet	Short Acting Narcotics	

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

Member Information

LAST NAME: **FIRST NAME:**

ID NUMBER: **DATE OF BIRTH:** – –

Prescriber Information

LAST NAME: **FIRST NAME:**

NPI NUMBER: **DEA NUMBER:**

PHONE NUMBER: – – **FAX NUMBER:** – –

Is the prescriber a TennCare provider with a Medicaid ID? ☐ Yes ☐ No

Is the prescriber a single-patient contract holder for this patient? ☐ Yes ☐ No

REQUESTED GENERAL/NON-PREFERRED DRUG

MEDICATION: _____ **STRENGTH:** _____ **DOSAGE FORM:** _____

DIRECTIONS: _____ **COMPOUND:** ☐ Yes ☐ No **DURATION OF THERAPY REQUESTED:** _____

MAY THE PATIENT USE THE GENERIC EQUIVALENT IF AVAILABLE? ☐ Yes ☐ No

Clinical Criteria Documentation

*****Do **not** include documentation that is not requested on this form*****

1. What is the diagnosis for which this drug is being requested? _____

2. Has the recipient failed an adequate trial of a preferred drug? ☐ Yes (please list) ☐ No

Drug 1	Strength	Length of Trial	Reason for discontinuation of the drug
Drug 2	**Strength**	**Length of Trial**	**Reason for discontinuation of the drug**

3. Has the recipient experienced an adverse event, or been intolerant to, a preferred drug? ☐ Yes ☐ No

   If yes, please list the drug (or drugs) and describe the adverse event or intolerance:

4. Is the patient currently taking the requested medication? ☐ Yes ☐ No

   If so, how was the medication supplied?

Please note any other information pertinent to this PA request: _____

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

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

Fax This Form to: 1-866-434-5523

Mail requests to: TennCare Pharmacy Program
c/o Magellan Health Services
1st floor South, 14100 Magellan Plaza
Maryland Heights, MO 63043
Phone: 1-866-434-5524

Magellan Health Services will provide a response within 24 hours upon receipt.

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