DEPARTMENT OF HUMAN SERVICES

Magellan Rx MANAGEMENT

Minnesota Health Care Programs
Prescription Drug Reconsideration Request Form

Print

Reset

Fax this form to 866-390-2778. A fax cover sheet is not required.

Date of Request: _____

MEMBER INFORMATION

Member Last Name: _____

Member First Name: _____

Member ID: _____ Date of Birth: _____ Member Phone: _____

PROVIDER INFORMATION

Provider Name: _____ Provider NPI: _____

Provider Phone: _____ Provider Fax: _____

DRUG INFORMATION

Drug Name: _____ Drug Form: _____

Drug Strength: _____ Dosing Frequency: _____

Member's Full Name: _____

REQUEST INFORMATION

Date of Original Request: _____ Date of Denial Notification: _____

1. Originally requested by: ☐ Pharmacy ☐ Prescriber
2. Is additional information being submitted? The requester is encouraged to submit any additional information to support the request for appeal (e.g., clinic notes and dates of previous medication trials).

   ☐ Yes ☐ No
3. **Rationale/medical reason for disagreement** (attach additional information if needed):

☐ Attachments

Mail requests to:

Magellan Rx Management, LLC
Attn: GV – 4201
P.O. Box 64811
St. Paul, MN 55164-0811

Phone: 844-575-7887

Fax this form to 866-390-2778