UNC Health Care Affiliate Health Plan Prior Authorization Form

Antimalarials

This form must be completed by the prescriber or authorized personnel. INCOMPLETE FORMS WILL BE RETURNED.

**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:  

**Requested Medication**

Drug:  
Strength:  
Quantity:  
Directions:  

**Clinical Criteria Documentation**

1. Does the patient have active malaria  
   - Yes  
   - No

2. Is the patient traveling to a country that requires malaria prophylaxis? Please specify country:  

3. Is the patient chloroquine resistant?  
   - Yes  
   - No

4. Is the patient traveling to a country with known chloroquine resistance?  
   - Yes  
   - No

**Prescriber Signature (Required)**

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

Fax This Form to: 866-272-4093

Mail Requests to: Magellan Rx Management Prior Authorization Program; c/o Magellan Health, Inc.  
4801 E. Washington Street Phoenix, AZ 85034

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