

BRAND NAME MEDICATION

Patient name: _____ Medicaid ID #: _____

Prescriber Name: _____ Prescriber NPI#: _____ Contact person: _____

Prescriber Phone#: _____ Extension/Option: _____ Fax#: _____

Pharmacy: _____ Pharmacy Phone#: _____ Pharmacy Fax #: _____

Requested Medication: _____ Pharmacy NPI#: _____ Strength: _____ Frequency/Day: _____

All information to be legible, complete and correct or form will be returned

FAX DOCUMENTATION FROM PROGRESS NOTES TO 855-828-4992

CRITERIA:

- Explanation of why treatment was initiated with the branded product OR
- Details of adverse reaction, allergy or inadequate response to the generic equivalent

NOTES:

- Many extended-release branded products do not have extended-release generic equivalents. In these cases, an adequate trial of the short-acting generic product is required.
- Prior authorizations for brand name medications require physician evaluated, charted documentation of an allergic reaction or adverse reaction. Patient complaints of lack of efficacy are not acceptable reasons for failure such as “Client said”, “client reports”, “doesn’t work” or “causes nausea.”

AUTHORIZATION:

One year

RE-AUTHORIZATION:

Updated letter of medical necessity

10/03/2016