

BRAND MEDICALLY NECESSARY PRIOR AUTHORIZATION FORM

- Please complete all applicable sections of this prior authorization request form and return to the fax number above. Please include all requested documentation (chart notes, laboratory data, etc.).

PRIOR AUTHORIZATION REQUEST INFORMATION			PRESCRIBER INFORMATION		
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info (PA#: _____)	# of pages in request: _____	Prescriber name:		
Name of office contact:			Specialty:		
Contact's phone number:			State license #:		
LTC facility contact/phone:			NPI:	MA Provider ID#:	
RECIPIENT INFORMATION			Street address:		
Recipient Name:			Suite #:	City/state/zip:	
Recipient ID#:	DOB:	Phone:	Fax:		

CLINICAL INFORMATION

Name of <u>brand name</u> drug requested:	Strength:	
Directions:	Quantity:	Refills:
Diagnosis:	Diagnosis code (required):	
1. Did the Recipient try taking the FDA-approved generic equivalent product?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Submit documentation of:</u> <ul style="list-style-type: none"> <u>generic medication tried</u> <u>dates and duration of treatment with the generic product</u>
2. Did the Recipient experience therapeutic failure with the generic product?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Submit documentation of</u> <ul style="list-style-type: none"> <u>generic medication tried</u> <u>chart notes, physical exam, lab data, imaging studies, etc. that support therapeutic failure of the generic product</u>
3. Did the Recipient experience any adverse events from the generic product that would not be expected to occur with the brand name product?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Submit documentation of</u> <ul style="list-style-type: none"> <u>adverse events experienced</u> <u>clinical rationale why the Recipient is not expected to experience these adverse events with the brand name product</u>
4. Does the Recipient have a contraindication to an ingredient in the generic product that is not contained in the brand name product?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Submit documentation of</u> <ul style="list-style-type: none"> <u>name of the contraindicated ingredient that is contained in the generic product but not the brand product</u>
5. What is the medical justification for the Recipient requiring the brand name product? <u>Record justifications in the space provided, and submit all documentation supporting the use of the brand name product.</u>		

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date:
------------------------------	--------------

Confidentiality Notice: The documents accompanying this telecopy may contain confidential information belonging to the sender. The information is intended only for the use of the individual named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any telecopy is strictly prohibited.