



Brand Name Drug Request Form

(KY -MAP-82101, revised 6/1/10)

Approval does not ensure eligibility. Please verify Medicaid eligibility before completing this form.

FAX to 800-365-8835

OR MAIL to Pharmacy Department, 1st floor South, 14100 Magellan Plaza, Maryland Heights, MO 63043
For **URGENT** Requests Only, FAX to **800-421-9064** For **NURSING FACILITY** Requests Only, FAX to **800-453-2273**

Submitted form must be signed by prescriber **

Use this form to request a brand name drug when generic forms of the drug are available. Please provide medical justification why the individual cannot be appropriately treated with the generic form of the drug.

RECIPIENT NAME	MEDICAID #	DATE OF BIRTH
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Magellan is directed to FAX a response to the following fax number (s):	<i>Prescriber Fax # (Print Clearly)</i>	<i>and/or</i>	<i>Pharmacy Fax # (Print Clearly)</i>

	PRESCRIBER Information	PHARMACY Information	
Name			
Phone # <i>(Not fax number)</i>			
NPI # <i>(Not DEA# or Any other #)</i>		NPI # <i>(Not DEA#)</i>	

	Brand Name Drug Requested <i>(Use separate form to request more than 2 drugs.)</i>	Dosage Form	Strength	Quantity	Directions for use	Start Date for this PA
1						
2						

	<i>Has patient recently been treated with generic forms of the requested brand name drug? Circle yes or no.</i>	<i>Hand write "Brand Medically Necessary"</i>	<i>Prescriber Signature ** (required to complete process)</i>
	Specify dosage and length of therapy with generic forms.		
1	Yes No		
2	Yes No		

HAS THE REQUESTED DRUG BEEN PRIOR AUTHORIZED PREVIOUSLY? [] YES [] NO [] UNKNOWN

PERTINENT DIAGNOSES _____

CURRENT MEDICATIONS _____

MEDICAL JUSTIFICATION (Indicate why the individual's medical condition cannot be adequately treated with generic forms of the drug. Provide any appropriate laboratory tests, blood levels, dates generic drugs prescribed by current/previous providers, or any other medical documents to support the request for the brand name drug.)

***If the patient had an adverse response to the generic form of the drug, have you submitted a MedWatch form to the FDA? [] Yes [] No
If yes, please include a copy with this form.

This authorization request is not a guarantee of payment. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information on this form and on accompanying attachments is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If this communication is received in error, the reader shall notify sender immediately and destroy all information received.