BRAND NAME
DRUG REQUEST FORM
(MAP-82101, revised 3/3/2003)

FAX to **866-863-8803** (toll free)

For **URGENT** Requests Only, FAX to **800-877-2219** (toll free)

For **NURSING FACILITY** Requests Only, FAX to **(866) 863-9171** (toll free)

MAIL to PA Unit, PO Box 2103, Frankfort, KY 40602. Put return address below:

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

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

RECIPIENT NAME	MAID #	DATE OF BIRTH

	PRESCRIBER Information	PHARMACY Information
Name		
Phone #		
Fax #		
License #		

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

	Has patient recently been treated with generic forms of the requested brand name drug? Circle yes or no. Specify dosage and length of therapy with generic forms.	Hand write "Brand Medically Necessary"	Prescriber Signature
1	Yes No		
2	Yes No		

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

PERTINENT DIAGNOSES _____

CURRENT MEDICATIONS _____

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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? If yes, please include a copy with this form.

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	LEAVE THIS SECTION BLANK
DRUG #1	
DRUG #2	