pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

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.).

☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Name of brand name drug requested:	Strength:	
Directions:	Quantity:	Refills:
Diagnosis:	Diagnosis code (*required*):	

Did the beneficiary try taking the FDA-approved generic equivalent product?	☐Yes ☐No	*Submit documentation of generic medication tried and dates and duration of treatment with the generic product.*
Did the beneficiary experience therapeutic failure with the generic product?	☐Yes ☐No	*Submit documentation of chart notes, physical exam, lab data, imaging studies, etc. that support therapeutic failure of the generic product.*
Did the beneficiary experience any adverse events from the generic product that would not be expected to occur with the brand name product?	☐Yes ☐No	*Submit documentation of adverse events experienced and clinical rationale why the beneficiary is not expected to experience these adverse events with the brand name product.*
Does the beneficiary have a contraindication to an ingredient in the generic product that is not contained in the brand name product?	☐Yes ☐No	*Submit documentation of name of the contraindicated ingredient that is contained in the generic product but not the brand product.*

What is the medical justification for the beneficiary requiring the brand name product? *Record justification in the space provided, and submit all documentation supporting the use of the brand name product.*

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

Prescriber Signature:	Date: