

FLORIDA MEDICAID PRIOR AUTHORIZATION

MULTI-SOURCE BRAND DRUG

Note: Form must be completed in full. An incomplete form may be returned.

Request for Multi-Source Brand Drug Due to Adverse Effects or Ineffectiveness of Generic
Note to Prescribing Physician: THIS FORM MUST BE SUBMITTED ALONG WITH A MISCELLANEOUS PRIOR
AUTHORIZATION FORM AND COPY OF THE PRESCRIPTION IF A REQUEST IS BEING MADE TO DISPENSE A BRAND
PRODUCT DUE TO ADVERSE EFFECTS OR INEFFECTIVENESS OF A GENERIC.

It is very important that physician's prescribe generic drugs whenever possible. Most FDA-approved generics are bioequivalent and therapeutically equivalent to the brand name drug. This request form is **ONLY** to be used if your patient has experienced an adverse medical reaction to the generic drug or if you can document that your patient has had better medical results when taking the multi-source brand drug, as opposed to its generic substitute.

Rec	ipien	t's N	ledic	aid I	ID#					_		Date	Pate of Birth (MM/DD/YYYY)																
														1			1												
			<u> </u>																										
Rec	ipien	ťs F	ull N	lame)	I		I		I								I										1 1	
Prescriber's Full Name															·			·		ı		·	· ·						
Pres	cribe	er's	Full	Nam	e 	1									1	1		1		1			1		1			1 1	
Prescriber's NPI																													
															Dungarihan Fay North														
Prescriber Phone Number													Prescriber Fax Number																
			-				-														-				-				
			1																	1			1						
		(Give	labe				ROD mfr/l			know	n)				REQUESTED BRAND PRODUCT (Give labeled strength & mfr/labeler, if known)													
(Give labeled strength & mfr/labeler, if known) Name:													Name:																
Mai	Manufacturer:													Ма	Manufacturer:														
ND	C#:														ND	NDC#:													
Stre	Strength:													Str	Strength:														
Dos	Dose, Frequency, & Route Used:														Do	Dose, Frequency, & Route Used:													
															Dia	Diagnosis for Use (Indication):													
The	Therapy Dates (if unknown, give duration) from/to (or best														Die	Diagnosis for Ose (indication).													
esti	estimate):																												
Dia	Diagnosis for Use (Indication):																												
	ADVERSE EVENT															BENEFITS OF BRAND PRODUCT													
Des	Describe event or problem with generic:														Describe how brand will alleviate problem:														
(Mu	(Must provide medical record documentation describing adverse event)												(Must provide medical record documentation describing adverse event)																
٥.	4																		Б.										
Sigi	nature	∋:																	Dat	e:									

Fax or mail completed forms to:

Prime Therapeutics State Government Solutions LLC Prior Authorization P.O. Box 7082

Tallahassee, FL 32314-7082 Phone: 877-553-7481 Fax: 877-614-1078 Confidentiality Notice: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender (via return fax) immediately and arrange for the return or destruction of these documents. Distribution, reproduction or any other use of this transmission by any party other than the intended recipient is strictly prohibited.