Print Form Reset Form

OMBUDSMAN PROJECT

AGENCY FOR HEALTH CARE ADMINISTRATION

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 TO AHCA WITH A MISCELLANEOUS PA 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.

PATIENT INFORMATION	PRESCRIBING PHYSICIAN
Full Name:	**Name:**
Medicaid ID #:	**Address:**
Date of Birth:	
SSN:	**Phone #:**
Sex: ☐ Female ☐ Male	**Licence #:**
	Fax #:
Weight: lb.(s)	**Signature:**

GENERIC PRODUCT (Give labeled strength & mfr/labeler, if known)	REQUESTED BRAND PRODUCT (Give labeled strength & mfr/labeler, if known)
Name:	**Name:**
Manufacturer:	**Manufacturer:**
NDC#:	**NDC#:**
Strength:	**Strength:**
Dose, Frequency, & Route Used:	**Dose, Frequency, & Route Used:**
Therapy Dates (if unknown, give duration) from/to (or best estimate):	**Diagnosis for Use (Indication):**
Diagnosis for Use (Indication):	

ADVERSE EVENT	BENEFITS OF BRAND PRODUCT
Describe event or problem with generic:	**Describe how brand will alleviate problem:**
(Must provide medical record documentation describing adverse event)	(Must provide medical record documentation describing adverse event)

REQUIRED FOR REVIEW: Copies of medical records (i.e. diagnostic evaluations and recent chart notes), the original prescription, and the most recent copies of related labs.

The provider must retain copies of all documentation for five years.

Fax or mail completed forms to:
Magellan Medicaid Administration, Inc.
Prior Authorization
P. O. Box 7082
Tallahassee, FL 32314-7082
Phone: 877-553-7481
Fax: 877-614-1078