NEBRASKA MEDICAID PROGRAM REQUEST FOR PRIOR AUTHORIZATION OF PAYMENT DOCUMENTATION OF MEDICAL NECESSITY

PRESCRIBING PHYSICIAN:

Name: _____
(First, Last)

Phone #: (_____)-_____-_____

Fax #: (_____)-_____-_____

NPI #: _____

MEDICAID RECIPIENT:

Name: _____
(First, Last)

Medicaid # _____

Date of Birth: _____/_____/_____

(Note: patient must be 16 years or older)

PARTICIPATING PHARMACY:

Name: _____ **Request Date:** _____/_____/_____

Phone #: (_____) _____-_____ **Fax #:** (_____) _____-_____

This request is being submitted for the following

Drug Name: **Strength:** **Administration Schedule:**

_____

Please provide patient-specific information which supports the medical necessity of the requested medication as opposed to another currently available covered alternative.

1. Diagnosis related to use: _____
2. Expected duration of therapy: _____
3. Alternative medications tried for this diagnosis:

   Drug: _____ Dose: _____ Date: _____ Outcome: _____

   Drug: _____ Dose: _____ Date: _____ Outcome: _____

   Drug: _____ Dose: _____ Date: _____ Outcome: _____
4. Patient's Weight: _____ Patient's Height: _____
5. Additional pertinent information: (*please include clinical reasons for drug, relevant lab values, etc.*):

_____

_____

_____

Prescriber Signature: _____ Date: _____
(With this signature, the prescriber confirms that the information above is accurate and verifiable in patient records.)

Please note: Pharmacy Services may request chart documentation to verify the above information.
Submit requests to: Pharmacy Services Fax: 833-404-2254 Tel: 844-330-7852
Submit your prior authorization (PA) requests electronically through our preferred solution **CoverMyMeds** at CoverMyMeds.com/main/prior-authorization-forms/.