NEBRASKA MEDICAID PROGRAM REQUEST FOR PRIOR AUTHORIZATION OF PAYMENT
DOCUMENTATION OF MEDICAL NECESSITY FOR QUANTITY LIMIT OR HIGH DOSE OVER RIDE

PRESCRIBING PHYSICIAN:

Name: _____
(First Last)

Phone #: (_____)-_____-_____

Fax #: (_____)-_____-_____

NPI #:_____

MEDICAID RECIPIENT:

Name:_____
(First Last)

Medicaid # _____

Date of Birth: __/__/_____

PARTICIPATING PHARMACY:

Name:_____

Request Date:_____

Phone #: (_____)-_____-_____

Fax #: (_____)-_____-_____

Requested Drug: **Strength and Quantity:** **Administration Schedule:**

_____

THIS SECTION MUST BE COMPLETED AND SIGNED BY THE PRESCRIBER:

DRUG QUANTITY LIMIT OR HIGH DOSE OVERRIDE

1. Specific diagnosis:_____
2. Maximum recommended dose per prescribing literature:_____
3. Detailed description of reason patient needs a greater quantity or dose greater than FDA recommends:_____
   _____
4. If dosing is weight-based or body surface area-based:
   Patients Weight: _____Patients Height: _____

Prescriber Signature:_____**Date:**_____

(With this signature, the prescriber confirms that the information above is accurate and verifiable in patient records.) **Please note:** Nebraska Total Care request chart documentation to verify the above information.

Submit request to: Pharmacy Services Fax: 833-404-2254, Tel: 844-330-7852
Submit prior authorization (PA) requests electronically through our preferred solution **CoverMyMeds** at CoverMyMeds.com/main/prior-authorization-forms/.