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

PRESCRIBING PROVIDER:

Name: _____
First **Last**

Phone #: (____)-_____

Fax #: (____)-_____

NPI # _____

MEDICAID RECIPIENT:

Name: _____
First **Last**

Medicaid #: ☐☐☐☐☐☐☐☐☐☐☐

Date of Birth: ☐☐/☐☐/☐☐☐☐

PARTICIPATING PHARMACY:

Name: _____ **Request Date:** _____

Phone #: (____)-_____

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:

   Patient's Weight: _____ Patient's Height: _____

Prescriber Signature: _____ **Date:** _____
(With this signature, the prescriber confirms that the information above is accurate and verifiable in patient records.)
Please note: The Department may request chart documentation to verify the above information.

Submit requests to: **Magellan Medicaid Administration, Inc.** **Fax: 1-866-759-4115**
Tel: 1-800-241-8335