Nebraska Medicaid Program Request for Prior Authorization of Payment
Documentation of Medical Necessity for Quantity Limit or High Dose Override

If the following information is not complete, correct, or legible, the PA process can be delayed. Use one form per member please.

Member Information

LAST NAME:

FIRST NAME:

MEDICAID NUMBER:

DATE OF BIRTH: – –

Prescriber Information

LAST NAME:

FIRST NAME:

NPI NUMBER:

DEA NUMBER:

PHONE NUMBER: – –

FAX NUMBER: – – –

This request is being submitted for the following:

MEDICATION: _____ **STRENGTH:** _____ **ADMINISTRATION SCHEDULE:** _____

MEDICATION: _____ **STRENGTH** _____ **ADMINISTRATION SCHEDULE:** _____

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MEDICATION: _____ **STRENGTH** _____ **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. Alternative medicines tried for this diagnosis:

   _____
4. If dosing is weight-based or body surface area-based:

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

_____ _____

Prescriber Signature (Required) ***Date***

(By signature, the Physician confirms the above information is accurate and verifiable by patient records.)

Please note: the Department may request chart documentation to verify the above information.

Fax This Form to: 866-759-4115

or mail to

Prime Therapeutics State Government Solutions LLC, MAP Dept.

Attn: GV – 4201

P.O. Box 64811

St. Paul, MN 55164-0811

Tel: 1-800-241-8335