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

B. Alternative medications tried for this diagnosis: Drug: Dose : Date: Outcome: Drug: Dose : Date: Outcome: Drug: Dose : Date: Outcome: Patient's Weight: Patient's Height:	_	KLSCKIDIN	IG PHYSICIAN:	<u>!</u>	MEDICAID RECIP	<u>TENI:</u>	
First Last Phone #: ()	ame:			Name:			
Date of Birth:		irst	Last		First	Last	
Comparison of the region of	none #: (_)		Medicaid #:			
PARTICIPATING PHARMACY: Name: Request Date: Phone #: () Fax #: () This request is being submitted for the following Strength: Administration Schedule: Please provide patient-specific information which supports the medical necessific requested medication as opposed to another currently available covered alternation. Diagnosis related to use: 2. Expected duration of therapy:	ax #: (_)		Date of Birth:			
Request Date: Phone #: ()	기#			(NOTE: Patient	must be 18 years	or older.)	
Phone #: ()	ARTICIPAT	TING PHARI	MACY:				
Please provide patient-specific information which supports the medical necessite equested medication as opposed to another currently available covered alternation. Diagnosis related to use: Expected duration of therapy: Drug: Dose: Drug: Dose: Date: Drug: Dose: Drug: Dose: Date: Date: Outcome: Drug: Dose: Drug: Dose: Date: Date: Outcome: Drug: Drug: Dose: Drug: Dose: Drug: Dose: Date: Date: Date: Drug: Dose: Date: Drug: Dose: Drug: Dose: Drug: Dose: Drug: Dose: Date: Drug: Dose: Drug: Dose: Drug: Dose: Date: Drug: Dose: Date: Drug: Dose: Date: Date: Date: Drug: Dose: Drug: Dose: Drug: Dose: Drug: Dose: Date: Drug: Dose: Drug: Dose: Date: Drug: Dose: Date: Date	ame:			Request Dat	te:		
Please provide patient-specific information which supports the medical necessite requested medication as opposed to another currently available covered alternation. Diagnosis related to use: Expected duration of therapy: Alternative medications tried for this diagnosis: Drug: Dose: Date: Outcome: Drug: Dose: Date: Outcome: Drug: Dose: Date: Outcome: Patient's Weight: Patient's Height:	none #: ()		Fax #: (_)		
requested medication as opposed to another currently available covered alternation. Diagnosis related to use: Expected duration of therapy: Alternative medications tried for this diagnosis: Drug: Drug: Dose: Date: Drug: Dose: Drug: Date: Drug: Dose: Drug: Date: Drug: Date: Drug: Date: Drug: Date: Drug: Drug							
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. Patient's Weight: Patient's Height:	Drug:		Dose :	Date:	Outcome	e:	
•	Drug:		Dose :	Date:	Outcome	e:	
. Additional pertinent information: (please include clinical reasons for drug, relevant lab values, etc.):	Patient's \	itient's Weight:			Patient's Height:		
	Additional	I pertinent inf	formation: (please inc	clude clinical reasons for	drug, relevant lab	values, etc.):	
Prescriber Signature: Date: Date: With this signature, the prescriber confirms that the information above is accurate and verifiable in patie	escriber S	Signature:			Date:		

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