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 18 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: 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