Nebraska Medicaid Program Request for Prior Authorization of Payment
Documentation of Medical Necessity

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:** ______

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MEDICATION: ______ **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 medicines tried for this diagnosis:

   DRUG: ______ **DOSE:** ______ **DATE:** ______ **OUTCOME:** ______

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   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 (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.

Revised: October 2024

Fax This Form to: 866-759-4115
or mail to
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