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NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Prime THERAPEUTICS™

Nebraska Medicaid Program

Request for Prior Authorization

Documentation of Medical Necessity for Quantity Limit or High Dose Override

Fax this form to 866-759-4115.

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

MEMBER INFORMATION

Member Last Name: _____

Member First Name: _____

Medicaid ID: _____ Date of Birth: _____

PRESCRIBER INFORMATION

Prescriber Last Name: _____

Prescriber First Name: _____

Prescriber NPI: _____ DEA Number: _____

Prescriber Phone: _____ Prescriber Fax: _____

DRUG REQUESTED

This request is being submitted for the following:

Medication: _____ Strength: _____

Administration Schedule: _____

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Administration Schedule: _____

Medication: _____ Strength: _____

Administration Schedule: _____

Member's Name: _____

DRUG QUANTITY LIMIT OR HIGH DOSE OVERRIDE

This section must be completed and signed by the prescriber:

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:

   Member's Weight: _____ kg Member's Height: _____ cm

Prescriber Signature: _____ **Date:** _____

(Required)

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

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: 800-241-8335