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

PRESCRIBING PROVIDER:

Name: ________________________________
First **Last**

Phone #: (____)-_________________________

Fax #: (____)-___________________________

NPI # ___________________________________

MEDICAID RECIPIENT:

Name: ________________________________
First **Last**

Medicaid #: ☐☐☐☐☐☐☐☐☐☐☐

Date of Birth: ☐☐/☐☐/☐☐☐☐

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.*):

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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