

**Health New England
Medication Request Form
Multisource Brands**

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

Prior Authorization

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Quantity approved:
PA from and thru date:
PA #
Denied:
Returned:

Instructions:

This form is to be used by participating physicians and pharmacy providers to obtain coverage of multisource brand medications (brand-name multiple-source drugs that have an FDA "A"-rated generic equivalent). Please complete this form and fax to Health New England at 413-233-2777 and please allow 3-15 days to process. If you have any questions regarding this process, please contact Health New England Member Services Department at (800) 310-2835.

Medication Request Information (please complete each section of this form prior to transmittal):

Patient Information (all required)	Physician Information (all required)
Patient Name:	Physician Name:
Patient HNE ID#:	Specialty:
Patient Date of Birth:	NPI #:
Allergies:	HNE Provider #:
Diagnosis:	DEA # (required):
	Area Code and Telephone #: () -
	Area Code and Fax # (required): () -

Drug Information

Current Generic Drug:	Dose, Directions, Length of Treatment:		
Requested Brand-Name Multisource Drug / Strength:			
Dose , directions and length of treatment (please be specific):		Quantity (per month):	Refills:
Physician signature:		Date:	

The following agents are excluded from this Prior Authorization:

Armour Thyroid	Coumadin	Creon	Depakene	Depakote
Dilantin	Lanoxin	Levothroid	Lithobid	Neoral
Pancrease	Prograf	Sandimmune	Synthroid	Tegretol
Tegretol XR	Theophylline products	Ultras	Unithroid	Levoxyl

Other Pertinent History (relative or pertaining to this request):

The following is necessary to complete a review:

<input type="checkbox"/> Does the patient have a documented allergic reaction to an excipient that is present in the generic formulation of the requested medication, but is absent in the brand name formulation? Please attach notes, documentation.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Did the member have a documented inadequate response? Please attach notes, documentation.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Did the patient receive samples from the prescriber and no history of filling a prescription for an available generic medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Did the prescriber complete and submit an FDA Medwatch Adverse Event Reporting Form? The provider shall provide a copy of the completed form.	<input type="checkbox"/> Yes <input type="checkbox"/> No