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 16 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: Envolve Pharmacy Solutions may request chart documentation to verify the above information.

Submit requests to: Envolve Pharmacy Solutions, Fax: 1-866-399-0929 Tel: 1-844-330-7852