NEBRASKA MEDICAID PROGRAM REQUEST FOR PRIOR AUTHORIZATION OF PAYMENT DOCUMENTATION OF MEDICAL NECESSITY FOR QUANTITY LIMIT OR HIGH DOSE OVER RIDE

PRESCRIBING PHYSICIAN:

Name: _____
First Last

Phone #: (_____)-_____-_____

Fax #: (_____)-_____-_____

NPI #: _____

MEDICAID RECIPIENT:

Name: _____
First Last

Medicaid # ☐☐☐☐☐☐☐☐☐☐

Date of Birth: ☐☐/☐☐/☐☐☐☐

PARTICIPATING PHARMACY:

Name: _____

Request Date: _____

Phone #: (_____)-_____-_____

Fax #: (_____)-_____-_____

Requested Drug: **Strength and Quantity:** **Administration Schedule:**

THIS SECTION MUST BE COMPLETED AND SIGNED BY THE PRESCRIBER:

DRUG QUANTITY LIMIT OR HIGH DOSE OVERRIDE

1. Specific diagnosis: _____
2. Maximum recommended dose per prescribing literature: _____
3. Detailed description of reason patient needs a greater quantity or dose greater than FDA recommends: _____
_____
_____
4. If dosing is weight-based or body surface area-based:
Patients Weight: _____ Patients Height: _____

Prescriber Signature: _____ **Date:** _____
(With this signature, the prescriber confirms that the information above is accurate and verifiable in patient records.) **Please note:** Nebraska Total Care request chart documentation to verify the above information.

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