

FAX completed form to
Change Healthcare
1-866-964-3472

Wyoming Medicaid – Pharmacy Services Program
PRIOR AUTHORIZATION REQUEST FORM
Brand Name Medication Required

PHONE:
For questions or inquiries (ONLY)
1-877-207-1126

Provider must fill in ALL information below. It must be legible, correct and complete or form will be returned.

Client ID #: _____

Client's Full Name: _____ DOB: _____

Prescriber NPI: _____

Prescriber's Full Name: _____ Phone: _____

Prescriber Address: _____ Fax: _____

Pharmacy NPI: _____

Pharmacy Name: _____ Phone: _____

ONE Drug Per Form ONLY

<u>Brand Drug Name</u>	<u>Strength</u>	<u>Dosage Instructions</u>	<u>Days Supply</u>	<u>Quantity</u>	<u>Refills</u>
------------------------	-----------------	----------------------------	--------------------	-----------------	----------------

Has client tried a generic?

- No
- Yes
 - Adverse reaction
 - Inadequate response
 - Other _____

Details of adverse reaction, inadequate response, or other: (please provide chart notes if available)

Is the side effect experienced also listed in the Brand Name Medication Side Effect Profile? If no please explain.

What other therapeutic alternatives other than the name brand version were tried first?

MEDICAL JUSTIFICATION (Please indicate why the individual's medical condition cannot be adequately treated with generic forms of the drug. ***If the patient had an adverse reaction to the generic form of the drug, have you submitted a MedWatch form to the FDA? If yes, please include a copy with this form. **IF NO, ONE MUST BE INCLUDED WITH THIS REQUEST.** A MedWatch form may be obtained at <http://www.fda.gov/medwatch/report.htm>.)

Prescriber Signature: _____ **Date of Submission:** _____

** Prescriber's original signature required; copied, stamped, or e-signatures are not allowed. By signature, the prescriber confirms the criteria information above is accurate and verifiable in client records.*