C:02.18

FAX completed form to
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

Brand Drug Name	Strength	Dosage Instructions	Days Supply	Quantity	Refills

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.