ProCare Rx

Brand Medically Necessary

Ticket #: _____ Request Date: _____ Request Time: _____

PHYSICIAN CERTIFICATION PRIOR AUTHORIZATION FORM

A request for the patient identified below has been made for the dispensing of brand medically necessary medication. Based on recent clinical information, we require more information before this prescription can be paid by the patient's health benefit plan. Please fill out the following information and return to us as indicated below:

A. Member Information

Patient Name:	Plan Name/Plan ID:	
Patient ID:	Patient Date of Birth:	Patient Contact Phone #:

B. Physician Information

Physician Name:	Physician Address:		
Physician DEA #:	Physician Phone #:	Physician Fax #:	
Drug Name and Strength:	Direction (SIG):	QTY and Days Supply:	NDC #:

C. Pharmacy Information

Pharmacy Name:	NABP #:	Pharmacy Phone #:	Pharmacy Fax #:

D. Clinical Information (Please fill out the following information: circle all that apply)

1. Has the member experienced a clinical significant adverse reaction or an allergic reaction to the generic equivalent drug? YES NO
   If YES, indicate the adverse reaction that can be directly attributed to the generic equivalent drug, dose and approximate dates the drug was taken: _____

2. Has the member experienced a treatment failure with the generic equivalent drug? YES NO
   If YES, indicate the treatment failure that can be directly attributed to the generic equivalent drug, dose and approximate dates the drug was taken:
   _____

3. Please explain how the brand medically necessary drug will prevent reoccurrence of the adverse reaction, treatment failure, or allergic reaction described in previous questions 1 and 2:
   _____

4. Does the member have a medical condition that causes a contraindication to the use of the generic equivalent drug? YES NO
   If YES, please indicate the medical condition: _____

   <u>For narrow therapeutic index drugs</u>:
   For the following drugs: Any brand name **anticonvulsant drug** used to treat a seizure disorder, **Clozaril, Coumadin, Neural or Prograf**.

5. Does the member's past medical history suggest an anticipated treatment failure of the generic equivalent? YES NO
   If YES, attach the prescriber's documentation of the anticipated therapeutic failure and the past medical history that forms the basis of the anticipated therapeutic failure.

Authorized Medical Signature:	
Telephone:	Date:

<u>When Completed Return To</u>:

ProCare PBM Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507
1-866-965-Drug (3784) / Fax # 866-999-7736

**Please note that this form is to be completed by the prescribing physician. This form and its contents are permissible under HIPAA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). HIPAA does restrict the communication of PHI with providers for TPO related purposes.