Pharmacy Brand Name Prior Authorization Request Form

FOR USFHP ONLY

For Internal Use Only
PA#:
Date Entered:

Fax completed form AND APPLICABLE PROGRESS NOTES to: 410-424-4037
Please contact the Pharmacy department at 888-819-1043 option 4 with any questions.

Step 1

Patient Information (please print)		**Provider Information (please print)**
Patient Name:		Provider Name:
Address:		Address:
Sponsor ID #:	Date of Birth:	Phone #:
		Secure Fax#:

Medication Information

Please indicate which medication is being prescribed:

Step 2

Please consider the following:

- 32 CFR 199.21 (j)(2) Use of generic drugs under the pharmacy benefits program. The pharmacy benefits program generally requires mandatory substitution of generic drugs listed with an "A" rating in the current Approval Drug Products with Therapeutic Equivalence Evaluations (Orange Book) published by the FDA and generic equivalents of grandfather or Drug Efficacy Study Implementation (DESI) category drugs for brand name drugs. In cases in which there is a clinical justification for a brand name drug in lieu of a generic equivalent, under the standards and procedures of paragraph (h)(3) of this section, the generic substitution policy is waived.
- The generic products are A- rated by the Food and Drug Administration for a bioequivalence and therapeutic equivalence to the brand name product. An A-rated product will produce comparable absorption and blood levels to the brand name products, "products evaluated as that based on its determination of therapeutic equivalence between generic and innovator drug products, "products evaluated as therapeutically equivalent can be expected to have equivalent clinical effect whether the product is brand name or generic drug product."

1. Has the patient tried the generic product? ☐ **Yes** ☐ **No**
   If "yes," please proceed to question 2. If "no," please proceed to question 4.
2. Did the patient experience a significant adverse reaction to the generic? ☐ **Yes** ☐ **No**
   If "yes" or "no," please proceed to question 3.
3. Please provide an explanation of the patient's experience with the generic, then proceed to step 3:
4. Please provide patient-specific clinical justification as to why the A-rated generic product cannot be used, then proceed to step 3:

Step 3 Please sign and date:
I certify that the above is correct and accurate to the best of my knowledge.

Prescriber Signature: _____ Date: _____

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☐ Approved	Duration of Approval _____ month (s)
☐ Denied	Authorized By:
☐ Incomplete/Other	Name:
Date Faxed to MD:	Date Decision Rendered: