State of Maine Department of Health &Human Services
MaineCare/MEDEL Prior Authorization Form
BRAND NAME MEDICATION REQUEST

Phone: 1-888-445-0497 **www.mainecarepdl.org** Fax: 1-888-879-6938

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

Member ID #: |__|__|__|__|__|__|__|__|__|__| (NOT MEDICARE NUMBER) Patient Name: _____ DOB: _____

Patient Address:_____

Provider DEA: |__|__|__|__|__|__|__|__|__| Provider NPI: __|__|__|__|__|__|__|__|__|__|

Provider Name:_____ Phone:_____

Provider Address:_____ Fax:_____

Pharmacy Name:_____Rx Address:_____Rx phone:_____

(Pharmacy use only): NPI: __|__|__|__|__|__|__|__|__|__| NABP: |__|__|__|__|__|__|__| NDC: |__|__|__|__|__|__|__|__|__|__|__|

****THIS FORM IS TO BE USED WHEN THE MEMBER HAS TRIED, AND FAILED OR IS INTOLERANT OF THE PREFERRED MORE COST EFFECTIVE GENERIC FORMULATIONS. ****

Drug Brand Name	Strength	Dosage Instructions	Quantity	Days Supply (34 retail / 90 mail order)	Refills
_____	_____	_____	_____	_____	1 2 3 4 5

Has member tried a generic?

- ❑ Yes
  - o Adverse reaction
  - o Inadequate response
  - o Other _____

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

_____

_____

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

_____

_____

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

_____

_____

According to MaineCare Benefits Manual Chapter II (80.07-5), when medically necessary covered brand-name drugs have an A-rated generic equivalent available, the most cost-effective medically necessary version will be approved and reimbursed, since the brand-name and A-rated generic drugs have been determined by the FDA to be chemically and therapeutically equivalent.

The Bureau does not make determinations as to whether or not a generic drug is clinically inferior or inequivalent to its brand version. This is the proper role of the FDA. Providers should submit their reports of generic inequivalence directly to the FDA via the MEDWATCH.

Approvals or denials will be issued based on whether the criteria in the form have been satisfied. If this form is used to submit PA requests for non-preferred brands that involved failing FDA-designated equivalent generics, a denial will almost certainly be issued. If the Department determines however, that the information supplied indicates a highly probable and serious adverse drug effect that is unique to the generic and not to the brand, then it will issue an interim approval after forwarding a report to the FDA, and while awaiting a response back from the FDA.

Pursuant to the MaineCare Benefits Manual, Chapter I, Section 1.16, The Department regards adequate clinical records as essential for the delivery of quality care, such comprehensive records are key documents for post payment review. Your authorization certifies that the above request is medically necessary, meets the MaineCare criteria for prior authorization, does not exceed the medical needs of the member and is supported in your medical records.

Provider Signature: _____ Date of Submission: _____
***MUST MATCH PROVIDER LISTED ABOVE**

Please complete both pages of this PA request

Provider Help Desk
1 (888) 420-9711

State of Maine Department of Health &Human Services
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FAX Completed Form to
1 (888) 879-6938

BRAND NAME MEDICATION REQUEST

Revised for submission of brand medically necessary requests for the MaineCare or MEDEL.
Prescriber must have witnessed or have documentation that the manifestation of adverse event(s) is linked to the generic drug
Completion of form does not automatically grant approval.

A. PATIENT INFORMATION

MEDICAID ID# _____ DOB ___/___/____

NAME_____ Sex ☐M ☐F

WEIGHT_____lbs. Phone # (___)_____-_____

Has a generic been tried before? Yes___ No ___

Give date: ____/____/____ Age at time of event:_____

B. ADVERSE EVENT OR INADEQUATE RESPONSE

❑ Adverse Event ❑ Inadequate response

2. Outcomes Attributed to Adverse Event *(Check all that apply)*

- ❑ Death: _____ *(mo/day/year)*
- ❑ Disability
- ❑ Life-threatening event
- ❑ Congenital Anomaly
- ❑ Required Intervention to Prevent Permanent Impairment/Damage
- ❑ Hospitalization-Initial or Prolonged

Date of Event (mo/day/yr)	Date of This Report (mo/day/yr)

Describe Event or Problem; Relevant History and Tests

C. SUSPECT MEDICATIONS

Name *(Give labeled strength & mfr. Labeler, if known)*

Dose, Frequency & Route Used:	Therapy Dates:

Diagnosis for Use (*Indication*)

Lot# *(If Known)*	Exp. Date

NDC # *(specify generic manuf.)*

Event Abated After Use Stopped or Dose Reduced?

Yes ❑ No ❑ N/A ❑

Event Reappeared After Reintroduction?

Yes ❑ No ❑ N/A ❑

D. DEGREE OF CERTAINTY THAT THE ADVERSE REACTION IS DUE TO GENERIC

___ **Definite.** The reaction follows a reasonable temporal sequence after generic drug exposure or a toxic blood level of the generic drug has been established in body fluids or tissue. The reaction follows a recognized response to the suspected generic drug. The reaction is confirmed by improvement on withdrawing the generic drug and reappears on re-exposure. "Other than drug causes" such as other drugs or toxins or concomitant disease states that can cause similar clinical reactions are ruled out.

___**Probable.** The reaction follows a reasonable temporal sequence after generic drug exposure. The reaction follows a recognized response to the suspected generic drug. The reaction is confirmed by withdrawal but not by exposure to the generic drug. The reaction cannot be reasonably explained by known characteristics of the recipient's clinical state.

___**Possible.** The reaction follows a temporal sequence after generic drug exposure. The reaction follows a possible recognized pattern to the suspected generic drug. The reaction could be explained by the recipient's clinical state (i.e. other than the suspected generic drug).

___**Doubtful.** The reaction is likely to be related to factors other than the suspected generic drug.

___**Negative.** The findings clearly eliminate the possibility of a drug reaction caused by the generic version of the drug.

List concomitant medications being taken by patient:

E. REPORTER

Prescriber's Name_____
Signature_____DEA#_____
Address _____
_____
Phone# : (____) _____-_____
Fax # : (____) _____-_____

Did the prescriber witness the ADR? Yes ☐ No ☐☐☐
Has the ADR been reported to the FDA? Yes ☐ No ☐☐☐

Please FAX form to
GHS at 1-888-879-6938
DO NOT FAX DIRECTLY TO THE FDA

Please complete both pages of this PA request