SoonerCare
Oklahoma Health Care Authority

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

Statement of Medical Necessity for Brand-Name Drug Override

Pharmacy Management Consultants
Prior Authorization Unit

Phone: 405-522-6205 Opt 4 or 1-800-522-0114 Opt 4
Fax: 405-271-4014 or 800-224-4014

After completing this form, please **fax** this form and any requested documentation to Pharmacy Management Consultants.
Please make sure that the member's ID Number is on every page faxed.

THIS SECTION IS TO BE COMPLETED BY THE PHARMACY:

Member Name:	Member ID Number:
Member Date of Birth:	Dispensing Pharmacy Phone Number:
Dispensing Pharmacy Name:	Dispensing Pharmacy Fax Number:
Dispensing Pharmacy NPI:	Requested Drug Name & Strength:
Requested Drug NDC Number:	Requested Drug Monthly Quantity:
Requested Drug Dosing Regimen:	Requested Drug Fill Date:
Prescriber Name:	Prescriber NPI:
Prescriber Phone Number:	Prescriber Fax Number:

THIS SECTION MUST BE COMPLETED AND SIGNED BY THE PRESCRIBER:

Patient needs the requested brand-name drug rather than its FDA approved generic equivalent because:

- ❑ **Patient experienced an adverse event while using the generic medication.**
- ❑ **The generic medication was not effective for the patient.**
- ❑ **Other (Please explain):** _____

Please answer the following questions about what happened when the patient took the generic medication:

1. **Generic medication taken** (Give labeled strength, mfr/labeler, lot #, & exp. date, if known)**:**

   _____

   _____

2. **Dose, frequency, & route used:**

   _____

3. **Date(s) patient took the generic medication** (give from/to or best estimate)**:**

   _____

   _____

4. **Diagnosis for use:**

   _____

Member ID Number (REQUIRED):

5. Description of adverse event or problem:

_____

_____

_____

_____

6. How long after beginning use of drug did the event occur?

_____

7. Outcomes attributed to adverse event caused by generic medication:

- ❑ **Life-threatening** ❑ **Hospitalization – initial or prolonged** ❑ **Disability**
- ❑ **Intervention was required to prevent permanent impairment/damage**
- ❑ **Other:** _____

8. Event abated after use stopped or dose reduced? ❑ **Yes** ❑ **No** ❑ **Doesn't apply**

If yes, how long after stopping or reducing dose of drug did event abate?

_____

9. Event reappeared after reintroduction? ❑ **Yes** ❑ **No** ❑ **Doesn't apply**

10. Concomitant medical products & therapy dates:_____

_____

_____

11. Relevant Tests/Laboratory Data, Including Dates:_____

_____

12. Other Relevant History, Including Preexisting Medical Conditions (e.g., allergies, race, pregnancy, smoking and alcohol use, hepatic/renal dysfunction, etc.)**:**

_____

_____

_____

13. Patient's drug/excipient allergies:

_____

14. Patient's Weight: _____

15. Patient's Height: _____

**** OHCA may request additional supporting documentation.****

Prescriber Signature: _____ **Date:** _____ **(With this signature, the prescriber confirms that the information above is accurate and verifiable in patient records.)** http://www.okhca.org