

**Health New England  
Medication Request Form  
Multisource Brands**

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

**Prior Authorization**

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Quantity approved:
PA from and thru date:
PA #
Denied:
Returned:

**Instructions:**

This form is to be used by participating physicians and pharmacy providers to obtain coverage of multisource brand medications (brand-name multiple-source drugs that have an FDA "A"-rated generic equivalent). Please complete this form and fax to Health New England at 413-233-2777 and please allow 3-15 days to process. If you have any questions regarding this process, please contact Health New England Member Services Department at (800) 310-2835.

**Medication Request Information (please complete each section of this form prior to transmittal):**

Patient Information (all required)	Physician Information (all required)
<b>Patient Name:</b>	<b>Physician Name:</b>
<b>Patient HNE ID#:</b>	<b>Specialty:</b>
<b>Patient Date of Birth:</b>	<b>NPI #:</b>
<b>Allergies:</b>	<b>HNE Provider #:</b>
<b>Diagnosis:</b>	<b>DEA # (required):</b>
	<b>Area Code and Telephone #: (     )     -     </b>
	<b>Area Code and Fax # (required): (     )     -     </b>

**Drug Information**

<b>Current Generic Drug:</b>	<b>Dose, Directions, Length of Treatment:</b>		
<b>Requested Brand-Name Multisource Drug / Strength:</b>			
<b>Dose , directions and length of treatment (please be specific):</b>		<b>Quantity (per month):</b>	<b>Refills:</b>
<b>Physician signature:</b>		<b>Date:</b>	

***The following agents are excluded from this Prior Authorization:***

<b>Armour Thyroid</b>	<b>Coumadin</b>	<b>Creon</b>	<b>Depakene</b>	<b>Depakote</b>
<b>Dilantin</b>	<b>Lanoxin</b>	<b>Levothroid</b>	<b>Lithobid</b>	<b>Neoral</b>
<b>Pancrease</b>	<b>Prograf</b>	<b>Sandimmune</b>	<b>Synthroid</b>	<b>Tegretol</b>
<b>Tegretol XR</b>	<b>Theophylline products</b>	<b>Ultrase</b>	<b>Unithroid</b>	<b>Levoxyl</b>

***Other Pertinent History (relative or pertaining to this request):***

<input type="checkbox"/> Did the patient receive samples from the prescriber and no history of filling a prescription for an available generic medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Does the patient have a documented allergic reaction to an excipient that is present in the generic formulation of the requested medication, but is absent in the brand name formulation? Please attach notes, documentation.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Did the member have a documented inadequate response? Please attach notes, documentation.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Did the prescriber complete and submit an FDA Medwatch Adverse Event Reporting Form? The provider shall provide a copy of the completed form.	<input type="checkbox"/> Yes <input type="checkbox"/> No