



Request for Multi-Source Brand Drug Due to Adverse Effects or Ineffectiveness of Generic

Note to Prescribing Physician: THIS FORM MUST BE SUBMITTED TO AHCA WITH A MISCELLANEOUS PA FORM AND COPY OF THE PRESCRIPTION IF A REQUEST IS BEING MADE TO DISPENSE A BRAND PRODUCT DUE TO ADVERSE EFFECTS OR INEFFECTIVENESS OF A GENERIC.

It is very important that physician's prescribe generic drugs whenever possible. Most FDA-approved generics are bioequivalent and therapeutically equivalent to the brand name drug. This request form is only to be used if your patient has experienced an adverse medical reaction to the generic drug or if you can document that your patient has had better medical results when taking the multi-source brand drug, as opposed to its generic substitute.

PATIENT INFORMATION	PRESCRIBING PHYSICIAN
Full Name: _____ Medicaid ID #: _____ Date of Birth: _____ SSN: _____ Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male Weight: _____ lb.(s)	Name: _____ Address: _____ _____ Phone #: _____ Licence #: _____ Fax #: _____ Signature: _____
GENERIC PRODUCT (Give labeled strength & mfr/labeler, if known)	REQUESTED BRAND PRODUCT (Give labeled strength & mfr/labeler, if known)
Name: _____ Manufacturer: _____ NDC#: _____ Strength: _____ Dose, Frequency, & Route Used: _____ _____ Therapy Dates (if unknown, give duration) from/to (or best estimate): _____ _____ Diagnosis for Use (Indication): _____ _____	Name: _____ Manufacturer: _____ NDC#: _____ Strength: _____ Dose, Frequency, & Route Used: _____ _____ Diagnosis for Use (Indication): _____ _____ _____
ADVERSE EVENT	BENEFITS OF BRAND PRODUCT
Describe event or problem with generic: _____ _____ _____ (Must provide medical record documentation describing adverse event)	Describe how brand will alleviate problem: _____ _____ _____ (Must provide medical record documentation describing adverse event)

Fax or mail completed forms to:
 OMBUDSMAN PROJECT
 Medicaid Pharmacy Services
 2727 Mahan Drive, Mail Stop # 38
 Tallahassee, FL 32308
Fax: (850) 922-0685

For Information Only:
 Phone: (850) 487-4441

For AHCA Use Only			
DATE: _____			NOTIFIED: _____
APPROVED: _____	START DATE: _____	EXPIRATION DATE: _____	
DENIED: _____	REASON: _____		