# Alabama Medicaid Pharmacy
# Override Request Form

**FAX: (800) 748-0116**
**Phone: (800) 748-0130**

**Fax or Mail to**
**HEALTH INFORMATION DESIGNS**

**P.O. Box 3210**
**Auburn, AL 36831-3210**

## PATIENT INFORMATION

Patient name _____ Patient Medicaid # _____

Patient DOB _____ Patient phone # with area code _____ Nursing home resident ☐ Yes

## PRESCRIBER INFORMATION

Prescriber name _____ NPI # _____ License # _____

Phone # with area code _____ Fax # with area code _____

Address (Optional) _____
Street or PO Box /City/State/Zip

***I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I will be supervising the patient's treatment. Supporting documentation is available in the patient record.***

_____
**Prescribing Practitioner Signature** **Date**

## DISPENSING PHARMACY INFORMATION

Dispensing pharmacy _____ NPI # _____

NDC # _____ J Code _____ Qty. requested per month _____

Phone # with area code _____ Fax # with area code _____

## CLINICAL INFORMATION

☐ Early Refill ☐ Max Unit/Max Cost ☐ Therapeutic Duplication ☐ Brand Limit Switch Over

☐ DAW-1+ ☐ Accumulation Override ☐ Maintenance Supply Override ☐ Ingredient Duplication

Requested drug name _____ Strength _____ Date of request _____

**For Early Refill or Accumulation Override**

☐ Medication lost ☐ Physician changed the dosage ☐ Medication destroyed

☐ Medication stolen ☐ Patient going out of town for period greater than the day's supply remaining of the previous refill.

Documentation _____

☐ Supporting Documentation Attached

**For Maximum Unit or Maximum Cost or Maintenance Supply Override**

Diagnosis _____

Medical Justification _____

_____

**For Therapeutic Duplication, Ingredient Duplication or ◆Brand Limit Switch Over** **Diagnosis** _____

**Reason for Request** ☐ **Strength/Dosage change*** ☐ **Switch over** ☐ **Titration and Concomitant Therapy****

☐ Drug name _____ NDC _____ Qty. _____ Stop date _____ if applicable

☐ Drug name _____ NDC _____ Qty. _____ Stop date _____

Reason for change _____

* Stop date is required for strength/dosage change or switch over. ☐ Medical justification attached

** Attach medical justification if both drugs are to be continued (titration/concomitant therapy).

◆ For specific documentation requirement, see Override instructions on the Medicaid web site.

**For DAW=1 Override+** ☐ **Initial Request** ☐ **Renewal**

+ FDA Medwatch Form 3500 must be submitted to HID

## FOR HID USE ONLY

☐ Approve request ☐ Deny request ☐ Modify request ☐ Medicaid eligibility verified

Comments _____

_____ _____
Reviewer's Signature Response Date/Hour