

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

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 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