REQUEST FOR DRUG EVALUATION
Dispense as Written Brand Name Drug
Generic Advantage Program / MAC Penalty
FAX: 1-800-956-2397

Please complete all of the following Patient/Physician Information:

Patient Name: (Please Print)	
FLRx Patient ID number:	**Patient Birthdate:**
MD Name:	**MD Specialty:**
MD Phone #: ( )	**MD FAX #: ( )**
MD NPI #:	

Requested Drug:

Brand Drug Name	**Dosage**	**Frequency**

Primary Diagnosis: ______________________________

Was the exact generic equivalent drug attempted? □ Yes □ No

Drug: ______________________ **Strength** ________ **Frequency** __________

Period of Use: From ________ **To** __________ **(Please provide specific time period)**

Did the patient have a documented inadequate response to a minimum of a 4 week trial of the exact generic equivalent drug?	□ Yes	□ No
Did the patient have a documented allergic reaction to an excipient that is present in the generic formulation, but is absent in the brand name equivalent?	□ Yes	□ No
Did the patient have a documented life threatening side effect that required medical intervention to a generic medication that did not occur with the brand?	□ Yes	□ No

PLEASE SUBMIT PATIENT PROGRESS NOTES WITH ALL REQUESTS DOCUMENTING THE TRIAL OF THE GENERIC AND DESCRIBING THE OUTCOME OF THE TRIAL. PHARMACY RECEIPTS MAY BE REQUESTED. REQUESTS WILL NOT BE AUTHORIZED WITHOUT SUPPORTING DOCUMENTATION.

Explanation of Medical Necessity: ______________________________

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I certify that the above information is true and accurate to the best of my knowledge.

Prescriber Signature ______________________ **Date** ______________