

Wyoming Medicaid – Pharmacy Services Program

BRAND NAME DRUG REQUEST FORM

PHONE: 1-877-207-1126

MAIL: Goold Health Systems
P.O. Box 21719
Cheyenne, WY 82003-7032

FAX: 1-866-964-3472

Provider must fill all information below. It must be legible, correct and complete or form will be returned.

Recipient ID #: _____

Recipient's Full Name: _____ DOB: _____

Prescriber NPI: _____

Prescriber's Full Name: _____ Phone: _____

Prescriber Address: _____ Fax: _____

Pharmacy NPI: _____

Pharmacy Name: _____ Phone: _____

ONE Drug Per Form ONLY

<u>Brand Drug Name</u>	<u>Strength</u>	<u>Dosage</u> <u>Instructions</u>	<u>Quantity</u>	<u>Days Supply</u>	<u>Refills</u>				
					1	2	3	4	5
_____	_____	_____	_____	_____					

Has member tried a generic?

- No
- Yes
 - Adverse reaction
 - Inadequate response
 - Other _____

Details of adverse reaction, inadequate response, or other: (please provide chart notes.)

Is the side effect experienced also listed in the Brand Drug Side Effect Profile? If no please explain.

What other therapeutic alternatives other than the name brand version were tried first?

MEDICAL JUSTIFICATION (Please indicate why the individual's medical condition cannot be adequately treated with generic forms of the drug. ***If the patient had an adverse reaction to the generic form of the drug, have you submitted a MedWatch form to the FDA? If yes, please include a copy with this form. **IF NO, ONE MUST BE INCLUDED WITH THIS REQUEST.** A MedWatch form may be obtained at: <http://www.fda.gov/medwatch/report.htm>.)

Provider Signature: _____ **Date of Submission:** _____

*MUST MATCH PROVIDER LISTED ABOVE