OMBUDSMAN PROJECT

AGENCY FOR HEALTH CARE ADMINISTRATION

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: ____________	**Name:** ____________
Medicaid ID #: ____________	**Address:** ____________
Date of Birth: ____________	____________
SSN: ____________	**Phone #:** ____________
Sex: ☐ Female ☐ Male	**Licence #:** ____________
	Fax #: ____________
Weight: ____________ lb.(s)	**Signature:** ____________

GENERIC PRODUCT (Give labeled strength & mfr/labeler, if known)	REQUESTED BRAND PRODUCT (Give labeled strength & mfr/labeler, if known)
Name: ____________	**Name:** ____________
Manufacturer: ____________	**Manufacturer:** ____________
NDC#: ____________	**NDC#:** ____________
Strength: ____________	**Strength:** ____________
Dose, Frequency, & Route Used: ____________	**Dose, Frequency, & Route Used:** ____________
Therapy Dates (if unknown, give duration) from/to (or best estimate): ____________	**Diagnosis for Use (Indication):** ____________
Diagnosis for Use (Indication): ____________	

ADVERSE EVENT	BENEFITS OF BRAND PRODUCT
Describe event or problem with generic: ____________	**Describe how brand will alleviate problem:** ____________
(Attach Additional Information, if necessary)	(Attach Additional Information, if necessary)

Fax or mail completed forms to:
OMBUDSMAN PROJECT
Medicaid Pharmacy Services
2728 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:** ____________