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 DEA #:	**MD NPI #:**

Requested Drug:

Brand Drug Name	Dosage	Frequency

Primary Diagnosis: _____

Previous Therapies:

Drug: _____ **Strength** _____ **Frequency** _____

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

Does the patient have a documented allergic reaction to an excipient that is present in the generic formulation of the requested medication, but is absent in the brand name formulation? Please attach notes, documentation.	□ Yes	□ No
Did the member have a documented inadequate response? Please attach notes, documentation.	□ Yes	□ No
Did the prescriber complete and submit an FDA MedWatch Adverse Event Reporting Form? **THE PROVIDER MUST PROVIDE A COPY OF THE COMPLETED MEDWATCH FORM.** Authorization will not be considered unless the form is completed and submitted to the FDA.	□ Yes	□ No

Information regarding MedWatch, the FDA Safety Information and Adverse Event Reporting Program can be found at:
http://www.fda.gov/Safety/MedWatch

Explanation of Medical Necessity: _____

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

Prescriber Signature _____ **Date** _____

Please fax this information to:
FLRx Pharmacy Help Desk at 1-800-956-2397 or call 1-800-724-5033
Urgent Requests Only: 1(800) 208-4050 (fax)

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