



Clinical Justification – Mandatory Generic Substitution

Fax to INFORMEDRX PA Dept. 1-866-795-8834

INFORMEDRX Phone Number 1-866-795-0049

Product Applicability: **MassHealth** **Commonwealth Care** **Commercial**

PRESCRIBER INFORMATION

Name: _____ Specialty: _____

Office Contact: _____ NPI#: _____

Phone: _____ Fax: _____ Prescriber Signature: _____

Address: _____ City: _____ State: _____ Zip Code: _____

PATIENT INFORMATION

Name: _____ Date: _____

DOB: _____ Member BMCHP ID: _____

Diagnosis: _____ **Medication & Dose Requested:** _____

Brand name medications that have generic equivalents (AB rated) require prior authorization for coverage. Coverage is limited to patients with documented allergic reaction(s) to one of the excipients that is present in all available generic formulations, but is absent in the brand name formulation.

Previous Medications History		
Medication	Start and End date of Therapy	Specific allergic reaction/Others

Please describe unexpected outcome that constituted an allergy to the generic product.

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