Alabama Medicaid Pharmacy
Override Request Form

FAX: (800) 748-0116
Phone: (800) 748-0130

Fax or Mail to
HEALTH INFORMATION DESIGNS

P.O. Box 3210
Auburn, AL 36831-3210

PATIENT INFORMATION

Patient name XUOFJUBQUTFUYY, MARY MUG A Patient Medicaid # TESTINGSTATUS DATE

Patient DOB 02/03/2001 Patient phone # with area code 031-378-7562 Nursing home resident ☐ Yes

PRESCRIBER INFORMATION

Prescriber name Admin NPI # NPI_1234 License # 369TheGoose

Phone # with area code 215-343-5520 Fax # with area code 215-343-5521

Address (Optional) 1432 Easton Rd, Ste 3-G, Warrington, PA 18976
Street or PO Box/City/State/Zip

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I will be supervising the patient's treatment. Supporting documentation is available in the patient record.

Prescribing Practitioner Signature 03/25/2021 Date

DISPENSING PHARMACY INFORMATION

Dispensing pharmacy _____ NPI # _____

NDC # _____ J Code _____ Qty. requested per month _____

Phone # with area code _____ Fax # with area code _____

CLINICAL INFORMATION

☐ Early Refill ☐ Max Unit/Max Cost ☐ Therapeutic Duplication ☐ Brand Limit Switch Over

☐ DAW-1* ☐ Accumulation Override ☐ Maintenance Supply Override ☐ Ingredient Duplication

Requested drug name _____ Strength _____ Date of request _____

For Early Refill or Accumulation Override

☐ Medication lost ☐ Physician changed the dosage ☐ Medication destroyed
☐ Medication stolen ☐ Patient going out of town for period greater than the day's supply remaining of the previous refill.

Documentation _____
☐ Supporting Documentation Attached

For Maximum Unit or Maximum Cost or Maintenance Supply Override

Diagnosis _____

Medical Justification _____

_____

For Therapeutic Duplication, Ingredient Duplication or *Brand Limit Switch Over Diagnosis _____

Reason for Request ☐ **Strength/Dosage change*** ☐ **Switch over** ☐ **Titration and Concomitant Therapy****

☐ Drug name _____ NDC _____ Qty. _____ Stop date _____ if applicable

☐ Drug name _____ NDC _____ Qty. _____ Stop date _____

Reason for change _____

* Stop date is required for strength/dosage change or switch over. ☐ Medical justification attached
** Attach medical justification if both drugs are to be continued (titration/concomitant therapy).
• For specific documentation requirement, see Override instructions on the Medicaid web site.

For DAW=1 Override* ☐ **Initial Request** ☐ **Renewal**

*FDA Medwatch Form 3500 must be submitted to HID

FOR HID USE ONLY

☐ Approve request ☐ Deny request ☐ Modify request ☐ Medicaid eligibility verified

Comments _____

Reviewer's Signature Response Date/Hour