Alabama Medicaid Pharmacy

Override Request Form

FAX: (800) 748-0116	**Fax or Mail to**	**P.O. Box 3570**
Phone: (800) 748-0130	**KEPRO**	**Auburn, AL 36831-3210**

PATIENT INFORMATION

Patient name_____ Patient Medicaid #_____

Patient DOB_____ Patient phone # with area code_____ Nursing home resident ☐ Yes

PRESCRIBER INFORMATION

Prescriber name_____ NPI #_____ License #_____

Phone # with area code_____ Fax # with area code_____

Address (Optional)_____
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 **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 Kepro

FOR KEPRO USE ONLY

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

Comments_____

_____ _____
Reviewer's Signature Response Date/Hour