NEW YORK STATE EMPIRE PLAN PRESCRIPTION DRUG PROGRAM
GENERIC APPEAL AUTHORIZATION FORM

Please fill out ONE FORM FOR EACH DRUG APPEALED. (Form may be photocopied, as needed.) COMPLETE SECTIONS A & B. ASK YOUR PHYSICIAN TO COMPLETE SECTION C. Please do NOT substitute a physician's letter. **ANY OMISSIONS WILL DELAY THE PROCESSING OF THIS REQUEST.**

A. PATIENT'S SECTION

Cardholder ID number: _____ Patient ID#: _____ Patient DOB :_____

Pt. Last name: _____ Pt. First name: _____ MI: _____ Allergies:_____

Address (Include city,state/zip): _____ Phone number: ( )_____

B. DRUG INFORMATION

What is the name of the drug you are appealing? (ONE drug per form, please): _____

Why do **YOU** feel you need the brand name of this drug? _____

_____

I hereby authorize the release of my medication profile and medical history related to this appeal. I understand that by signing this document, I consent to the review of all pertinent medical information obtained through the physician prescribing the medication on this form. The information obtained on this form is confidential and will not be shared with your employer or plan sponsor.

_____ _____

Patient's signature Date

PLEASE HAVE YOUR PHYSICIAN FILL OUT THE REMAINDER OF THIS FORM AND RETURN IT TO US. YOU WILL BE NOTIFIED OF THE APPEAL PANEL'S DECISION IN WRITING. THANK YOU.

C. PHYSICIAN'S SECTION

ATTENTION PHYSICIAN: Please fill out ONE FORM for each drug appealed. Please type or print clearly and complete all information to assure a timely review. We welcome any additional documentation, references and comments, but please do NOT substitute a letter for this form. Thank you for your cooperation.

1. Brand name of drug being appealed:_____ Dose/SIG:_____

2. In your opinion, does this patient need the brand name of this drug? (PLEASE CHECK ONE):

____**NO** (If "no," then stop here, sign form and return) ____**YES** (If "yes," then complete remainder of form, sign and return)

3. Supporting diagnosis : _____

4. Which generic(s) **OF THIS BRAND NAME DRUG** has this patient tried in the past?

Generic name:_____ Manufacturer:_____ Start date:_____ Stop date:_____

Patient's response:_____ Additional information:_____

5. Please list the medical reason(s) why you feel this patient needs the brand name of this drug : _____

_____

6. Specific information regarding treatment failure with the generic drug is needed to assess the Generic Appeal. When appropriate, please list any specific values that suggest treatment failure (ie. blood pressures, blood sugars, side effects). _____

_____

As this patient's physician who is prescribing the brand name drug listed in this document, I certify that all the information regarding this patient's medication and medical history is, to the best of my knowledge, correct and complete.

_____ _____

Physician's signature Date

_____ _____

Physician's name **(PLEASE PRINT)** FAX number (include area code)

_____ _____

Street address / City / State / Zip code Phone number (include area code)

Please return this form to: **Empire Prescription Drug Program, Empire BlueCross BlueShield, P.O. Box 11826, Maildrop 3H, Albany, NY 12211**
Phone: (866) 223-7721; FAX: (518) 367-2883. The Generic Appeals Panel will review this request and your patient will be notified in writing of the Panel's decision. **Thank you.**