

**Clinical Justification
 Override of Mandatory Generic Program
 Fax to NMHCRX Latham @ 1-866-511-2202**

Patient Name _____ **Date** _____
ID# _____ **Submitted Group** BMCHLTH
DOB _____

Requested Brand Medication _____
Dose _____ **Duration of Therapy** _____

Review Information

Generic failure
 Please describe unexpected outcome that constituted a failure of the generic product

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

Please list other generic medications within that class that have been tried

<input type="checkbox"/> _____	<input type="checkbox"/> Ineffective	<input type="checkbox"/> Complications	<input type="checkbox"/> Duration of therapy _____
<input type="checkbox"/> _____	<input type="checkbox"/> Ineffective	<input type="checkbox"/> Complications	<input type="checkbox"/> Duration of therapy _____
<input type="checkbox"/> _____	<input type="checkbox"/> Ineffective	<input type="checkbox"/> Complications	<input type="checkbox"/> Duration of therapy _____
<input type="checkbox"/> _____	<input type="checkbox"/> Ineffective	<input type="checkbox"/> Complications	<input type="checkbox"/> Duration of therapy _____

Physician Signature _____
Name _____
Contact number/pager _____ **Fax** _____

(NMHCRX use only)

Approved (date & time) _____ (initial/continuation) _____ Duration _____
 Pending for more information _____ Faxed to MD (date & time) _____
 Sent to plan for further review (date & time) _____
 Reviewer Name _____ Ext _____