BOSTON MEDICAL CENTER
HealthNet Plan

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

❑ _____	❑ Ineffective	❑ Complications	❑ Duration of therapy _____
❑ _____	❑ Ineffective	❑ Complications	❑ Duration of therapy _____
❑ _____	❑ Ineffective	❑ Complications	❑ Duration of therapy _____
❑ _____	❑ Ineffective	❑ Complications	❑ 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 _____

NMHCRX
Pharmacy Benefits Manager