BRAND NAME DRUG AUTHORIZATION REQUEST

Submit form to: **Kenai Peninsula Borough School District**
ATTN: Stacey Gorder, Employee Benefits Manager
148 N. Binkley St. Soldotna, AK 99669
***OR* Fax to: (907) 262-9645**

Patient Name (last,first,MI):		**Patient ID Number:**
Sex:	**DOB:**	**Phone Number:**
Insured's Name:		

Name of Member's Health Plan: Rehn & Associates	
Date of Request:	**Physician's Name:**
MD office Contact Person:	**Physician's Phone Number:**
Physician's Fax Number:	**Physician's Specialty:**

Pharmacy Name:	**Pharmacy Fax Number:**
Pharmacy Contact:	**Pharmacy Phone Number:**

MEDICATION REQUEST ***Physician's Signature: _____**

Medication request information is to be completed by a physician.

DIAGNOSIS (*list relevant*):

CURRENT MEDICATION(S):

FORMULARY & GENERIC DRUGS TRIED & MEDICAL JUSTIFICATION:

DRUG & STRENGTH:	**NDC:**
DIRECTIONS:	**MONTHLY QTY:** **#REFILLS:**

FOR INTERNAL USE ONLY

Approved ___ Denied ___ Deferred for Additional Information ___ Approved As Modified ___ Pt. Not Eligible ___

COMMENTS: _____

Authorizing Signature _____ Date _____

Instructions for the KPBSD Brand Name Drug Authorization Request form

Effective October 1, 2011 if you purchase a brand name medication when a generic equivalent is available, you will pay the difference in price between the brand and generic, in addition to the brand co-pay. The purpose of this form is to waive this penalty if due to side-effects, complications, or intolerance, the member cannot use a preferred or generic substitute; or the clinical efficacy of the non-preferred drug has been shown to exceed the effectiveness of the referred or generic alternative. You must have tried the generic and the reason must be medically justified. If this request is approved, you will only pay the applicable brand name drug co-pay.

The employee or eligible dependent may fill out the top section which includes their Name, ID number, Sex, DOB, Phone number, Physician's office information and Pharmacy information.

The physician MUST sign the form and completely fill out the section titled "Medication Request". Before submitting the form, please verify that the information provided is legible.

Once the form has been completed it may be submitted via fax or mail.

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