Brand-Generic Rx Drug Appeal Form

Cleveland Heights-University Heights City Schools Health Plan

MD Name		Patient Name	
Address		Cardholder ID	
City		Medication (Name/Strength)	
State			
ZIP		DOB	
Phone		Address	
Fax		City/St/Zip	
NPI		Phone	

Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A Please answer the following questions

1. θ Yes θ No Has the patient experienced a genuine allergic reaction the generic equivalent medication, and do you anticipate the brand-name medication will not cause the same allergic reaction (i.e., the allergy can be attributed to an inactive ingredient)?
If **YES**, ***please document details of reaction.***

2. θ Yes θ No Has the patient experienced a clinically significant adverse reaction (excluding a lack of clinical effect) to the generic equivalent medication?
If **YES**, ***please document details of reaction.***

3. θ Yes θ No Has the patient experienced a failure in clinical treatment with the generic equivalent medication at the maximum dose for a minimum of 30 days?
If **YES*, Please document details of failure.***

4. θ Yes θ No Does the patient have a contraindication to any ingredient in the generic equivalent medication, which is not present in the brand name medication?
If **YES**, ***please document details of contraindication and ingredient.***

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Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1 440-572-6407

PLEASE DO NOT FAX WITH A COVER SHEET