Blue Care Network of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Dispense As Written (DAW) Medication Request Form

Attn: MedImpact Prior Authorization Department
10680 Treena Street, Suite 500
San Diego, CA 92131
Tel: 800-788-2949 Fax: 858-790-7100

Date _____

☐ **Urgent**

To request prior authorization for coverage of a brand name drug when a generic alternative is available, **please complete this form in its entirety** and fax to Med**Impact** Healthcare Systems, Inc. at 858-790-7100 . Please mail the original, completed FDA MedWatch form to the FDA, as instructed on the form. If you have any questions regarding this process, contact Med**Impact** Customer Service department at 800-788-2949.

Review Criteria:
When a generic version of a formulary drug is available that meets FDA bioequivalence requirements, Blue Care Network provides coverage for the generic. Members can obtain the brand-name by paying the difference between the brand-name and generic versions, plus their applicable copayment. If you, the prescriber, have evidence that the generic caused health problems for this patient, see next bullet.

Blue Care Network's (BCN) Prior Authorization Criteria for a BRANDED drug:
The patient experienced an adverse event or lack of efficacy with the generic formulation **and** documentation of the problem is provided by the **attached FDA MedWatch Form** (information and online forms are available through: https://www/accessdata.fda.gov/scripts/medwatch/). Please forward a **copy** of the submitted MedWatch form with this request. Forward the original MedWatch form to the FDA.

ALL REQUESTED INFORMATION MUST BE PROVIDED FOR CONSIDERATION FOR COVERAGE.
PLEASE TYPE OR PRINT CLEARLY

Step 1: Patient & physician information

Patient Information

Name: _____

DOB: _____

Member ID#: _____

Physician Information

Name: _____

NPI/DEA#: _____

Phone: _____

Fax: _____

Step 2: Medication requested

Drug Name: _____ Strength: _____ Duration: _____

Sig: _____ Diagnosis: _____

Step 3: Reason for medication request

Check all that apply

☐ The patient experienced failure while on all available generic versions of the requested drug.

☐ Patient has exhibited an intolerance (adverse reaction, allergy/sensitivity) to the generic versions of the requested drug.

☐ A completed MedWatch form has been submitted to the FDA and a copy is included with this request.

Step 4: List previously used formulary medications

Drug name, strength, specific reason the generic was not tolerated, and reason for discontinuation.

_____

_____

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FAX COMPLETED FORM AND SUPPORTING DOCUMENTATION TO
858-790-7100

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