



**NEW YORK STATE EMPIRE PLAN PRESCRIPTION DRUG PROGRAM  
GENERIC APPEAL AUTHORIZATION FORM**

Please fill out ONE FORM FOR EACH DRUG APPEALED. (Form may be photocopied, as needed.) COMPLETE SECTIONS A & B. ASK YOUR PHYSICIAN TO COMPLETE SECTION C. Please do NOT substitute a physician's letter. **ANY OMISSIONS WILL DELAY THE PROCESSING OF THIS REQUEST.**

**A. PATIENT'S SECTION**

Cardholder ID number: \_\_\_\_\_ Patient ID#: \_\_\_\_\_ Patient DOB : \_\_\_\_\_  
Pt. Last name: \_\_\_\_\_ Pt. First name: \_\_\_\_\_ MI: \_\_\_\_\_ Allergies: \_\_\_\_\_  
Address (Include city,state/zip): \_\_\_\_\_ Phone number: ( ) \_\_\_\_\_

**B. DRUG INFORMATION**

What is the name of the drug you are appealing? (ONE drug per form, please): \_\_\_\_\_  
Why do **YOU** feel you need the brand name of this drug? \_\_\_\_\_

I hereby authorize the release of my medication profile and medical history related to this appeal. I understand that by signing this document, I consent to the review of all pertinent medical information obtained through the physician prescribing the medication on this form. The information obtained on this form is confidential and will not be shared with your employer or plan sponsor.

\_\_\_\_\_  
Patient's signature Date

**PLEASE HAVE YOUR PHYSICIAN FILL OUT THE REMAINDER OF THIS FORM AND RETURN IT TO US. YOU WILL BE NOTIFIED OF THE APPEAL PANEL'S DECISION IN WRITING. THANK YOU.**

**C. PHYSICIAN'S SECTION**

**ATTENTION PHYSICIAN:** Please fill out ONE FORM for each drug appealed. Please type or print clearly and complete all information to assure a timely review. We welcome any additional documentation, references and comments, but please do NOT substitute a letter for this form. Thank you for your cooperation.

1. Brand name of drug being appealed: \_\_\_\_\_ Dose/SIG: \_\_\_\_\_

2. In your opinion, does this patient need the brand name of this drug? (PLEASE CHECK ONE):  
 **NO** (If "no," then stop here, sign form and return)  **YES** (If "yes," then complete remainder of form, sign and return)

3. Supporting diagnosis : \_\_\_\_\_

4. Which generic(s) **OF THIS BRAND NAME DRUG** has this patient tried in the past?  
Generic name: \_\_\_\_\_ Manufacturer: \_\_\_\_\_ Start date: \_\_\_\_\_ Stop date: \_\_\_\_\_

Patient's response: \_\_\_\_\_ Additional information: \_\_\_\_\_

5. Please list the medical reason(s) why you feel this patient needs the brand name of this drug : \_\_\_\_\_

6. Specific information regarding treatment failure with the generic drug is needed to assess the Generic Appeal. When appropriate, please list any specific values that suggest treatment failure (ie. blood pressures, blood sugars, side effects). \_\_\_\_\_

As this patient's physician who is prescribing the brand name drug listed in this document, I certify that all the information regarding this patient's medication and medical history is, to the best of my knowledge, correct and complete.

\_\_\_\_\_  
Physician's signature Date

\_\_\_\_\_  
Physician's name (PLEASE PRINT) FAX number (include area code)

\_\_\_\_\_  
Street address / City / State / Zip code Phone number (include area code)