ROCKY MOUNTAIN HEALTH PLANS®

Brand Name Drug Request

Fax back to RMHP Pharmacy Dept. 833-787-9448

Member Name:	Date:
Member ID Number:	Physician Name:
Member DOB:	Specialty:
	Physician Address:
☐ Medicaid ☐ Private Pay	Phone #:
	Fax #:
	NPI/DEA#:

1. I am requesting _____ , the brand name version of _____
   (trade name of drug) (generic drug name)
   for the diagnosis of _____.
   (intended use of the drug)

Choose the correct statement below:

☐ The above named patient has been given a therapeutic trial of the generic drug that has resulted in (choose all that apply):
☐ therapeutic failure ☐ side effects/toxicity not associated with the brand name drug

☐ The above name patient has *not* been given a therapeutic trial of the generic drug. I want this patient to remain on the trade name version of the drug.

2. I recognized that the generic form of this drug has been evaluated by the FDA and deemed to be "A" rated/bioequivalent. I understand that the FDA's 90% confidence interval (CI) requirements for the ratio of the generic drug AUC to the innovator must lie completely within the interval (0.8-1.25). This means that the actual plasma concentration of the generic drug would differ by no more than 3% from the innovator. Stricter requirements would likely prevent lot to lot batches of drugs from being bioequivalent to themselves (brand or generic). (Note: The CI is commonly ***interpreted incorrectly*** as generic drug varying from the brand by 80-125%.)

3. It is my opinion that the brand name drug will not be associated with this adverse effect or therapeutic failure, because (check all that apply)
   ☐ the failure/toxicity resolved when patient was put back on brand name
   ☐ the timing and circumstances of the failure/toxicity is highly suggestive of the generic drug being the causative agent
   ☐ Other: (please describe)

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4. Description of adverse event or drug failure, including relevant laboratory values, tests, or other objective evidence of drug failure or adverse effect: (must be specific)

5. Outcome:
   ☐ Required hospitalization / ER visit ☐ Hospitalization prolonged
   ☐ Required drug D/C or dosage adjust ☐ Required office visit
   ☐ Required other intervention: (Explain, include details)

6. Rather than risk continued toxicity/therapeutic failure with this molecule, whether brand or generic, is the patient a candidate for a pharmacologically similar drug?
   ☐ No, I want to keep this patient on this drug, in trade name form
   ☐ Yes, I will start this patient on another drug to avoid future tolerability/safety/efficacy concerns with this molecule.

7. **I agree to fill out the FDA MedWatch form (provided by RMHP) to inform FDA of the apparent *non*-bioequivalence of this generic drug. I will return this form to RMHP.**

Physician Signature _____ Date _____

Incomplete forms will NOT be processed

Please note: This form is only to be used to request a brand name drug for which a bioequivalent generic exists. If approved, this would override the requirement for the patient to "pay the difference" between the cost of generic and the cost of brand name, depending on the member's specific pharmacy benefit. The member will still incur a brand name copayment.

Pharmacy Technician initials _____