

NARBHA PM FORM 3.16.10
1. MEDICATION PRE -ENROLLMENT 2. SAPT /INELIGIBLE CHILD REQUEST
3. PHARMACY EDIT NOTIFICATION

TO: Northern Arizona Regional Behavioral Health Authority
FAX: (855) 411-7559 **ATTN:** Pharmacy Support

FROM: (PRINT NAME) _____ **Provider Agency** _____

Requesting Medical Practitioner (Print Name): _____

DATE: ____/____/____ **FAX # of Sender:** _____

USE THIS FORM TO:

- #1** Enroll member into the Pharmacy System BEFORE BEING FULLY ENROLLED WITH NARBHA.
- #2** Add an ineligible (non TXIX/TXXI) Child or SAPT member into the Pharmacy System..
- #3** Request **3A.** restricted, non-formulary or brand name medication or lab; **3B.** "More than 30 day supply" of medications; **3C.** Too early medication refill.

*****PLEASE PRINT LEGIBLY*****

Complete Items Below for ALL Requests #1, #2, #3			
Member Name		CIS OR AHCCCS #	
(Please provide Social Security # if neither CIS ID or AHCCCS ID is available)			
#1, #2 Complete Items Below for Medication Pre-Enrollment & SAPT/ Ineligible Child			
Date of Birth		Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
EOC Start Date		Title XIX/XXI	<input type="checkbox"/> Yes <input type="checkbox"/> No
Population	<input type="checkbox"/> Child <input type="checkbox"/> Mental Health <input type="checkbox"/> Substance Abuse <input type="checkbox"/> SAPT <input type="checkbox"/> SMI		

#3 Pharmacy Edit Notification (PEN)		
#3A Request for (Circle One): Non-Formulary Brand Name		
Medications/ Labs	Dosages	Explain reasons & plan to transition to formulary med or other funding source. (e.g. clinical/safety concerns, failures, allergies/reactions)
Period Requested (See time limits): ____/____/____ to ____/____/____		
Time limits: * SMI NT19: up to 30days x 3 in 12 months (Atypical Neuroleptics only)		
* SMI NT19 Risperdal Consta: up to 1yr * T19/21: up to 6 months * SAPT Buprenorphine: up to 06/30/12		
(Circle One) 3B. "Refill Too Soon"		3C. More Than 30 Day Supply
Medication		Dosage
Medication		Dosage
Medication		Dosage