471-000-84 Form MC-6, "Prescriber Certification" Form and Completion Instructions

Use: Prescribers use Form MC-6, "Prescriber Certification" form, to certify that a brand-name product of a federal upper limit (FUL) or state maximum allowable cost (SMAC) designated drug is medically necessary for the treatment of a Medicaid client. Use of this form allows the Department to pay for the brand-name product at the estimated acquisition cost (EAC) for the brand-name drug product.

Number Prepared: The prescriber and pharmacist complete one copy of the three-part Form MC-6.

Completion: By federal regulation, Form MC-6 must contain the legible handwritten signature of the prescribing practitioner. Rubber stamp signatures or initials will not be accepted. Form MC-6 is completed as follows: The prescriber enters the patient's name, case number and ID; drug name, strength, and NDC; prescription number (if known), prescriber's name and prescriber's license number; name of the dispensing pharmacy, and pharmacy provider number; and certification dates. The prescriber must sign and date the form.

Distribution: The prescriber keeps one copy for his/her records and mails the original Form MC-6 to the pharmacist. The pharmacist submits the original Form MC-6 to the designated contractor. The pharmacist keeps the remaining copy.

Retention: The designated contractor retains its copy as needed. The pharmacist and the prescriber may retain their copies as long as they choose.

To view printable form click here: Prescriber Certification

Fax completed form to (866-759-4115) or mail to Magellan Medicaid Administration, Inc. MAP Dept. Attention: NE Senior Pharmacist, 11013 W. Broad St. Suite 500, Glen Allen, VA 23060

Nebraska Department of Health and Human Services - Medicaid
PRESCRIBER CERTIFICATION - this brand is medically necessary

Patient's Name (Please Print)	Patient's Case Number and ID
Drug Name and Strength	Drug NDC Number
Prescription Number (if known)	
Prescriber's Name	Prescriber's ID Number
Dispensing Pharmacy	Dispensing Pharmacy's Medicaid Number
Pharmacy Phone _____ Pharmacy Fax _____ Handwritten Signature of Prescriber _____ Date _____	Certification Dates FROM: _____ Date: (Month/Day/Year) TO: _____ Date: (Month/Day/Year)

MC-6 Rev. 8/12 (63010) - (Prev. version should not be used)