INDIANA HEALTH COVERAGE PROGRAMS (IHCP) PHARMACY BENEFIT
HIGH DOLLAR COMPOUNDED PRESCRIPTION CLAIM PRIOR AUTHORIZATION REQUEST FORM

MDwise
Fax to: (858) 790-7100
c/o MedImpact Healthcare Systems, Inc.
Attn: Prior Authorization Department
10181 Scripps Gateway Court, San Diego, CA 92131
Phone: (800) 788-2949

MDwise
A McLaren Company

Today's Date
☐☐ / ☐☐ / ☐☐☐☐

Note: This form must be completed by the prescribing provider.

****All sections must be completed or the request will be returned****

Patient's Medicaid # ☐☐☐☐☐☐☐☐☐☐☐☐	Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
Patient's Name	Prescriber's Name
Prescriber's IN License # ☐☐☐☐☐☐☐☐	Specialty
Prescriber's NPI # ☐☐☐☐☐☐☐☐☐☐	Prescriber's Signature
Return Fax # ☐☐☐ - ☐☐☐ - ☐☐☐☐	Return Phone # ☐☐☐ - ☐☐☐ - ☐☐☐☐
Check box if requesting retro-active PA ☐	Date(s) of service requested for retro-active eligibility (if applicable):

Note: Submit PA requests for retroactive claims (dates of service prior to eligibility determination, but within established eligibility timelines) with dates of service prior to 30 calendar days of submission separately from current PA requests (dates of service 30 calendar days or less and going forward).

PA Requirements:

1. Compound requested meets all Federal and State legal requirements ☐ Yes ☐ No
2. Pharmacist or prescriber has verified the validity of the claim; including quantity and components
   ☐ Yes ☐ No
3. Faxed documentation for clinical rationale or medical justification (medical chart records indicating previous trial of commercially available therapeutic alternatives, alternatives are unsuitable for use, no reasonable therapeutic alternatives, supporting literature, etc.) for use is attached
   ☐ Yes ☐ No If no, explain:_____