

**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



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 #	<input type="text"/>	Date of Birth	<input type="text"/> / <input type="text"/> / <input type="text"/>
Patient's Name	Prescriber's Name		
Prescriber's IN License #	<input type="text"/>	Specialty	
Prescriber's NPI #	<input type="text"/>	Prescriber's Signature	
Return Fax #	<input type="text"/> - <input type="text"/> - <input type="text"/>	Return Phone #	<input type="text"/> - <input type="text"/> - <input type="text"/>
Check box if requesting retro-active PA	<input type="checkbox"/>	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: _____

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