

**INDIANA HEALTH COVERAGE PROGRAMS (IHCP) PHARMACY BENEFIT
OPIOID WITH CONCURRENT BUPRENORPHINE/NALOXONE OR BUPRENOPRHINE
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 #	□□□□□□□□□□	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	<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).

Requested Medication	Strength	Quantity	Dosage Regimen	Diagnosis

Concurrent Opioid/Buprenorphine PA

Please check all that apply:

Prescriber of the buprenorphine/naloxone or buprenorphine has been notified and approves the use of prescribed opiate therapy. Please indicate buprenorphine/naloxone or buprenorphine prescriber's name: _____

Opiate therapy prescribed is 7 days or less.

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