INDIANA HEALTH COVERAGE PROGRAMS (IHCP) PHARMACY BENEFIT
PBM CALL CENTER 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).

Please check applicable categories:

☐ Severity Level 1 Drug-Drug Interaction ☐ Non-Preferred Agent

☐ Other_____

Requested Medication	Strength	Quantity	Dosage Regimen	Diagnosis
Has medication been previously provided? ☐ Yes ☐ No Date:_____				

Associated Medication History	Strength	Quantity	Dosage Regimen	Date(s) Used	Diagnosis

Please add a brief summary that would help document need for the above listed medications. Clinical Summary: A current plan of treatment and progress notes may be requested for documentation.

Note: For Severity Level 1 Drug-Drug Interactions, please provide clinical rationale and monitoring plans for the co-administration of contraindicated drug products. If requesting a non-preferred agent, please provide any relevant clinical rationale as to why (the) preferred agent(s) are unsuitable for use.