Antipsychotics

Medication Request Form (MRF) for Healthy Indiana Plan (HIP) and Hoosier Healthwise (HHW)
FAX TO: (858) 790-7100
c/o MedImpact Healthcare Systems, Inc.
Attn: Prior Authorization Department
10181 Scripps Gateway Court, San Diego, CA 92131 - Phone: 1-844-336-2677

Instructions:
This form is to be used by participating providers to obtain coverage for the drug listed above which requires *prior authorization*. Please complete this form and fax it to Med***Impact*** Healthcare Systems, Inc. at (858) 790-7100. If you have any questions regarding this process, please contact Med***Impact***'s Customer Service at (844) 336-2677.

Member/Provider Information:

MDwise Member's Name:	**Provider's Name:**
MDwise Member's ID #:	**Provider's Specialty:**
MDwise Member's DOB (mm-dd-yy):	**Provider's DEA #:** | **Provider's NPI #:**
Pharmacy used by MDwise Member:	**Provider's Telephone Number/Contact Name (xxx-xxx-xxxx):**
Pharmacy Telephone Number (xxx-xxx-xxxx):	**Provider's Fax Number (xxx-xxx-xxxx):**

Clinical Information:

Requested Drug(s):	
Dose and Quantity Requested for Each Drug:	
Date Requested:	**Length of Treatment** (please be specific)**:**
Documentation of Medical Necessity:	
REQUESTS FOR GREATER THAN 15 DAYS SUPPLY OF AN ATYPICAL ANTIPSYCHOTIC: Has the patient received and tolerated samples of the requested atypical antipsychotic? ☐ Yes ☐ No	

THERAPEUTIC DUPLICATION REQUESTS:

Are the medications identified in the therapeutic duplication being cross-tapered? ☐ Yes ☐ No

OR

Is the medication in history being discontinued or are there plans to discontinue the historical medication? ☐ Yes ☐ No

OR

Does the patient have a diagnosis of psychosis? ☐ Yes ☐ No

If yes, does the patient have a history of at least 4 weeks of therapy with clozapine (unless there is a contraindication, allergy, or intolerance to clozapine therapy) within the past 2 years? ☐ Yes ☐ No

If yes, please list the dose and dates of therapy: _____

AND

Are both antipsychotics in the therapeutic duplication prescribed by or in consultation with a psychiatrist?

☐ Yes ☐ No If yes, please list psychiatrist here: _____

AND

Does the patient have history of at least 4 weeks of single-agent therapy at an adequate dose for 2 different antipsychotics in the past 2 years? ☐ Yes ☐ No

If yes, please list the medications, doses, and dates of therapy:

OR

Does the patient have one of the following diagnoses?

bipolar affective disorder ☐ Yes ☐ No

unspecified episodic mood disorder ☐ Yes ☐ No

depressed mood disorder ☐ Yes ☐ No

If yes, are both antipsychotics in the therapeutic duplication prescribed by or in consultation with a psychiatrist?

☐ Yes ☐ No If yes, please list psychiatrist here: _____

AND

Does the patient have history of at least 4 weeks of single-agent therapy at an adequate dose for 2 different antipsychotics in the past 2 years? ☐ Yes ☐ No

If yes, please list the medications, doses, and dates of therapy:

Please include additional information to support the need for duplicate therapy: