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: 1-800-788-2949

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:
- ☐ Avonex
- ☐ Avonex Pen
- ☐ Avonex Administration Pack
- ☐ Rebif
- ☐ Rebif Rebidose
- ☐ Extavia
- ☐ Betaseron
- ☐ Plegridy

Dose and Quantity Requested:

Date Requested:	**Length of Treatment** (please be specific)**:**

Documentation of Medical Necessity (please check all that apply):

If requesting Avonex or Rebif:

Does the patient have a diagnosis of relapsing – remitting multiple sclerosis (RRMS)? ☐ Yes ☐ No

If no, please indicate diagnosis: ______________________________

If requesting Betaseron, Extavia, or Plegridy:

Does the patient have a diagnosis of relapsing – remitting multiple sclerosis (RRMS)? ☐ Yes ☐ No

If no, please indicate diagnosis: ______________________________

Has the patient tried or does the patient have a contraindication to at least TWO of the following agents?

Avonex	☐ Yes	☐ No	______________________________
Rebif	☐ Yes	☐ No	______________________________
Copaxone	☐ Yes	☐ No	______________________________
Tecfidera	☐ Yes	☐ No	______________________________
Gilenya	☐ Yes	☐ No	______________________________
Aubagio	☐ Yes	☐ No	______________________________

If yes to any of the above, please describe the reaction/response or CI to each medication in the space provided.