Pulmozyme® (dornase alfa)

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 1-844-336-2677.

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 (Area Code) Telephone Number/Contact Name:**
Pharmacy (Area Code) Telephone Number:	**Provider's (Area Code) Fax Number:**

Clinical Information:

Requested Drug: ☐ **Pulmozyme**	
Dose and Quantity Requested:	
Date Requested:	**Length of Treatment** (please be specific)**:**

Documentation of Medical Necessity:

1. Does the patient have a diagnosis of cystic fibrosis (CF)? ☐ Yes ☐ No
2. Is the request for once daily dosing? ☐ Yes ☐ No
   If no, has the patient tried once daily dosing? ☐ Yes ☐ No
3. Additional information: