Medication Request Form (MRF) for Healthy Indiana Plan (HIP) and Hoosier Healthwise

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:
It is highly recommended that pertinent chart notes are submitted with the PA request.

REQUESTS FOR INITIAL THERAPY:

1. Is a short-acting opioid requested for moderate to severe post-surgical pain or pain related to an acute injury? ☐ Yes ☐ No

   If yes, please describe, **including date** of surgery or injury:

   ____

   AND

   Please provide documentation of a clear plan for opioid dose tapering and discontinuation:

   ____

2. What is the diagnosis that contributes to the need for opioid analgesic therapy?

   ____

3. Which of the following non-pharmacological therapies have been utilized for the patient's pain?

   ☐ Thermotherapy/cryotherapy
   ☐ Massage therapy
   ☐ Spinal cord stimulation (SCS)
   ☐ Transcutaneous electrical nerve stimulation (TENS)
   ☐ Physical therapy
   ☐ Other: ____

   Please provide **dates** and **description** of any non-pharmacologic therapies noted above:

4. Which of the following non-opioid pharmacological therapies have been prescribed for the patient's pain?
   - ☐ NSAIDs (e.g., ibuprofen, naproxen)
   - ☐ Acetaminophen
   - ☐ Antidepressants (e.g., amitriptyline, citalopram, venlafaxine, bupropion, duloxetine)
   - ☐ Anticonvulsants (e.g., gabapentin, pregabalin)
   - ☐ Other: ____

   Please list **drugs, doses,** and **dates** of therapy:

5. Is a long-acting opioid analgesic requested for chronic use? ☐ Yes ☐ No

   If yes, have the risks of opioid therapy been discussed with the patient? ☐ Yes ☐ No

   AND

   Has a pain management plan been developed with clear treatment goals? ☐ Yes ☐ No

6. Does the prescribed pain regimen include more than one long-acting or more than one short-acting opioid analgesic to be used concurrently? ☐ Yes ☐ No

   If yes, has the patient experienced refractory pain despite concurrent therapy with one short-acting opioid and one long-acting opioid? ☐ Yes ☐ No

   AND

   Has the prescriber consulted with the patient about the risks of opioid therapy and developed a pain management plan with clear treatment goals? ☐ Yes ☐ No

RENEWAL REQUESTS:

1. What is the diagnosis that contributes to the need for opioid analgesic therapy?
   ____

2. Is the request for continuation of either a short-acting or long-acting opioid analgesic therapy? ☐ Yes ☐ No

   If yes, please list the **drug, dose,** and **dates** of prior therapy:

   AND

   Has the opioid therapy resulted in a meaningful improvement in the patient's pain and/or function? ☐ Yes ☐ No

   AND

   Has an updated pain management plan been developed with clear treatment goals? ☐ Yes ☐ No

   AND

   Has risk assessment been performed including review of state prescription drug monitoring program? ☐ Yes ☐ No

   AND

   Has adherence to the prescribed opioid regimen been periodically assessed (e.g., urine drug screen, pill counts)? ☐ Yes ☐ No

3. Does the pain regimen include concurrent use of more than one long-acting or more than one short-acting opioid analgesic? ☐ Yes ☐ No

   If yes, is the pain refractory despite prior therapy with one short-acting opioid and one long-acting opioid? ☐ Yes ☐ No

   AND

   Has the prescriber consulted with the patient regarding the risks of opioid therapy and developed a pain management with clear treatment goals? ☐ Yes ☐ No