



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 MedImpact Healthcare Systems, Inc. at (858) 790-7100. If you have any questions regarding this process, please contact MedImpact'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:	
Dose and Quantity Requested:	
Date Requested:	Length of Treatment (please be specific):
Documentation of Medical Necessity (please check all that apply):	
1. What is the patient's diagnosis? _____	
2. Has the patient taken this medication in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please provide dates of prior therapy: _____	
3. Additional information:	