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 non-preferred formulations of buprenorphine/naloxone. 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 Med*Impact's* Customer Service at (800) 788-2949.

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:	**Quantity Requested:**
Strength and Dosage Regimen Requested:	**Date Requested:**

Documentation of Medical Necessity:

Did the patient have a hypersensitivity reaction to an inactive ingredient in generic buprenorphine/naloxone SL tablets (hypersensitivity reaction must be documented in submitted chart notes)?

☐ Yes ☐ No (Note: MedWatch form not required, but chart notes must be submitted.)

OR

Did the patient fail at least 28 days of treatment with generic buprenorphine/naloxone SL tablets in the previous 120 days due to therapeutic failure or adverse outcome that could not be addressed with dose adjustment?

☐ Yes ☐ No

Prior authorization is contingent upon your submission to the FDA of a completed MedWatch form which describes the therapeutic failure or adverse outcome(s) experienced by the patient with generic buprenorphine/naloxone SL tablets.

Is a copy of the MedWatch form submitted to the FDA attached to this request for prior authorization?

☐ Yes ☐ No

MedWatch forms can be downloaded at the following address:
http://www.fda.gov/downloads/AboutFDA/ReportsManualsForms/Forms/UCM163919.pdf

Please attach additional information which may indicate why the ***non-preferred*** medication is being requested for this patient.