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)**:**

REQUESTS FOR INITIAL SHORT-ACTING OPIOID THERAPY (initial criteria will apply to requests for an opioid not previously approved by MDwise)**:**

Note: If the patient is receiving concurrent benzodiazepine therapy, please ALSO submit the Benzodiazepine and Opioid Concurrent Therapy PA Request Form.

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 short-acting 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: ____

   ****Chart notes are required** to document **dates**, **description** and **duration** 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**:

   ____

   ____

   ****Chart notes are required** to document drugs, doses, and dates of therapy if there is no prescription claims history for these medication trials.

5. 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

6. Is the patient currently taking an antipsychotic medication? ☐ Yes ☐ No

   If yes, has the prescriber indicated that the concurrent use of an opioid and an antipsychotic medication is intended and clinically appropriate for the patient? ☐ Yes ☐ No

REQUESTS FOR INITIAL LONG-ACTING OPIOID THERAPY (initial criteria will apply to requests for an opioid not previously approved by MDwise)**:**

Note: If the patient is receiving concurrent benzodiazepine therapy, please ALSO submit the Benzodiazepine and Opioid Concurrent Therapy PA Request Form.

1. What is the diagnosis that contributes to the need for long-acting opioid analgesic therapy?

   ____

2. Is the patient opioid tolerant (defined as taking, for one week or longer, at least 60 morphine milligram equivalents (MME)/day such as 60mg oral morphine/day, 40mg oral oxycodone/day, 60mg oral hydrocodone/day, 400mg oral codeine/day, or an equianalgesic dose of another opioid)?

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

   ____

3. 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

4. Have the risks of opioid therapy been discussed with the patient? ☐ Yes ☐ No

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

6. Is the patient currently taking an antipsychotic medication? ☐ Yes ☐ No

   If yes, has the prescriber indicated that the concurrent use of an opioid and an antipsychotic medication is intended and clinically appropriate for the patient? ☐ Yes ☐ No

*** **Please continue to the next page to request <u>RENEWAL</u> OF EITHER SHORT- or LONG-ACTING OPIOID THERAPY*****

RENEWAL REQUESTS FOR EITHER SHORT- or LONG-ACTING OPIOID THERAPY (renewal criteria will apply to requests to continue an opioid previously approved by MDwise)**:**

Note: If the patient is receiving concurrent benzodiazepine therapy, please ALSO submit the Benzodiazepine and Opioid Concurrent Therapy PA Request Form.

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 (i.e., renewal of an opioid previously authorized by MDwise)? ☐ 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 INSPECT? ☐ 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

4. Is the patient currently taking an antipsychotic medication? ☐ Yes ☐ No

   If yes, has the prescriber indicated that the concurrent use of an opioid and an antipsychotic medication is intended and clinically appropriate for the patient? ☐ Yes ☐ No