



MHS INDIANA



MEDICATION PRIOR AUTHORIZATION REQUEST FORM

>>> Please DO NOT USE this form for Specialty and/or Biopharmaceutical Requests <<<

Submit the request by sending the completed form to US Script by FAX @ 1-866-399-0929 or MAIL to US Script c/o Prior Authorization Department at 2425 West Shaw Avenue, Fresno, California 93711

I. MEMBER INFORMATION		II. PRESCRIBER INFORMATION	
Name:		Name:	
ID Number:		Specialty:	
Gender:		NPI or DEA Number:	
Date of Birth:		Group or Hospital:	
Address:		Address:	
City, State, Zip:		City, State, Zip:	
Primary Phone:		Phone:	
Alternate Phone:		Fax:	
Medication Allergies:		Office Contact Name:	
III. MEDICATION REQUESTED (one medication request per form)			
Drug Name:		Dosage/Strength:	
Dosage Form:		Route of Admin:	
Quantity Per Day:		Directions:	
Refills/Length of Tx:		Therapy Start Date:	
IV. DIAGNOSIS (as relevant to this request)			
Diagnosis:		ICD9 and Description:	
Date of Diagnosis:		NOTE: Include diagnostic clinicals (labs, radiology, etc.).	
V. MEDICATION HISTORY (for this diagnosis)			
A. Is the member currently on this medication? <input type="checkbox"/> Yes; how long? _____ <input type="checkbox"/> No; skip to items B&C, go to D.			
B. Is this a request for continuation of a previous approval? <input type="checkbox"/> Yes; go to item C. <input type="checkbox"/> No; skip item C, go to D.			
C. Has the strength, dosage, or quantity required per day: <input type="checkbox"/> INCREASED <input type="checkbox"/> DECREASED <input type="checkbox"/> Remained the SAME			
D. Indicate PREVIOUS medications treatment/outcomes below. NOTE: Confirmation will be made using claims history.			
Drug Name, Strength, and Dosage	Dates of Therapy	Reason for Discontinuation	
1			
2			
3			
4			
VI. RATIONALE FOR REQUEST and PERTINENT CLINICAL INFORMATION			
<i>NOTE: Appropriate clinical information to support this request is required for all PA's. Attach additional sheets if more space is needed.</i>			
<input type="checkbox"/> Medical intolerance to the preferred drug. Provide clinical symptoms. <input type="checkbox"/> Inadequate response to the preferred drug. <input type="checkbox"/> Absence of appropriate formulation or indication of the drug. Please specify. <input type="checkbox"/> Other – Provide rationale for the request.			

Prescriber Signature – Dispense as Written (DAW):

Prescriber Signature – Substitution Permitted:

X _____ Date: _____

X _____ Date: _____

Please access www.mhsindiana.com or contact provider services for a current listing of preferred products. A response will be provided via fax or phone within one business day of the receipt of the complete information. Incomplete and illegible forms will delay processing. Be sure to include lab reports with requests when appropriate. To request a 72 hour emergency supply of medication you may call US Script at 1-855-772-7125. NOTE: The 72 hour supply does not apply to specialty medications. Requests can also be mailed to: US Script, c/o Prior Authorization Department, 2425 West Shaw Avenue, Fresno, California 93711.

CONFIDENTIALITY NOTICE: This facsimile transmission is intended to be delivered only to the name addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the name addressee, except by express authority of sender to the name addressee.