MHS PHARMACY BENEFIT

OPIOID WITH CONCURRENT BUPRENORPHINE/NALOXONE OR BUPRENOPRHINE PRIOR AUTHORIZATION REQUEST FORM

MHS
429 N Pennsylvania St. Suite 109
Indianapolis, IN, 46204-1208
Phone: (877) 647-4848 Fax: (866) 399-0929

Today's Date
☐☐ / ☐☐ / ☐☐☐☐

Note: This form must be completed by the prescribing provider.

****All sections must be completed or the request will be returned****

Patient's Medicaid # ☐☐☐☐☐☐☐☐☐☐☐☐	Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
Patient's Name	Prescriber's Name
Prescriber's IN License # ☐☐☐☐☐☐☐☐	Specialty
Prescriber's NPI # ☐☐☐☐☐☐☐☐☐☐	Prescriber's Signature
Return Fax # ☐☐☐ - ☐☐☐ - ☐☐☐☐	Return Phone # ☐☐☐ - ☐☐☐ - ☐☐☐☐
Check box if requesting retro-active PA ☐	Date(s) of service requested for retro-active eligibility (if applicable):

Note: Submit PA requests for retroactive claims (dates of service prior to eligibility determination, but within established eligibility timelines) with dates of service prior to 30 calendar days of submission separately from current PA requests (dates of service 30 calendar days or less and going forward).

Requested Medication	Strength	Quantity	Dosage Regimen	Diagnosis

Concurrent Opioid/Buprenorphine PA

Please check all that apply:

☐ Prescriber of the buprenorphine/naloxone or buprenorphine has been notified and approves the use of prescribed opioid therapy. Please indicate buprenorphine/naloxone or buprenorphine prescriber's name:_____

☐ Opioid therapy prescribed is 7 days or less.

If opioid therapy is expected to be used concomitantly with buprenorphine/naloxone or buprenorphine for greater than 7 days, please provide a brief explanation as to why opioid therapy is needed for a duration longer than plan permitted limits. Please provide plans regarding expected duration of opioid therapy as well as plans to taper off and discontinue opioid therapy.

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