MEDICATION PRIOR AUTHORIZATION REQUEST FORM
MANAGED HEALTH SERVICES (MHS)

FAX this completed form to (833) 645-2742

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:		ICD10 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? ☐**Yes**; how long? ☐**No**; skip items B&C, go to **D.**

B. Is this a request for continuation of a previous approval? ☐**Yes**; go to item **C.** ☐**No**; skip item C, go to **D.**

C. Has the strength, dosage, or quantity required per day: ☐**INCREASED** ☐**DECREASED** ☐ 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

NOTE: Appropriate clinical information to support this request is required for all PAs. Attach additional sheets if more space is needed.

☐ Medical intolerance to the preferred medications. Provide clinical symptoms.
☐ Inadequate response to the preferred medications.
☐ Absence of appropriate formulation or indication of the drug. Please specify.
☐ Other – Provider rationale for the request.

Prescriber Signature –

X ______________________________ Date: ______________

Please access mhsindiana.com or contact Provider Services for a current listing of preferred products. A response will be provided via fax or phone within 24 hours of the receipt of the complete information. Incomplete and illegible forms will delay processing. Be sure to include lab reports with requests when appropriate. ***NOTE: The 72-hour supply does not apply to specialty medications.***

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.