

**INDIANA HEALTH COVERAGE PROGRAMS PHARMACY BENEFIT
LTC AND HOME HEALTH PRODUR PRIOR AUTHORIZATION REQUEST FORM**



**Pharmacy Benefit Management (PBM) Call Center
4550 Victory Lane
Indianapolis, In 46203
Phone: (866) 879-0106 Fax: (866) 780-2198**



Today's Date

□□ / □□ / □□□□

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

Patient's Medicaid #	□□□□□□□□□□	Date of Birth	□□ / □□ / □□□□
Patient's Name	_____		
Prescriber's IN License #	□□□□□□□□	Specialty	_____
Prescriber's NPI #	□□□□□□□□□□	Prescriber's Signature	_____
Return Fax #	□□□□ - □□□□ - □□□□	Return Phone #	□□□□ - □□□□ - □□□□

***Please Note: Only 1 Patient per Request Form**

*RX #	□□□□□□□□□□	*Dispensed Date	□□ / □□ / □□□□
*Medication	_____	*Strength	_____
*Frequency	_____	*Quantity	_____
*Override Reason: _____			
<input type="checkbox"/> Early Refill	<input type="checkbox"/> High Dose (Dosage required to be confirmed by Prescriber)		
<input type="checkbox"/> Exact Duplicate	<input type="checkbox"/> Therapeutic Duplication (Must be confirmed with Prescriber)		

*RX #	□□□□□□□□□□	*Dispensed Date	□□ / □□ / □□□□
*Medication	_____	*Strength	_____
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<input type="checkbox"/> Early Refill	<input type="checkbox"/> High Dose (Dosage required to be confirmed by Prescriber)		
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