

**INDIANA HEALTH COVERAGE PROGRAMS PHARMACY BENEFIT  
PBM CALL CENTER PRIOR AUTHORIZATION REQUEST FORM**



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



Administered By ACS State Healthcare

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 Name		
Prescriber's IN License #	□□□□□□□□	Specialty	
Prescriber's NPI #	□□□□□□□□□□	Prescriber's Signature	
Return Fax #	□□□□ - □□□□ - □□□□	Return Phone #	□□□□ - □□□□ - □□□□

Please check applicable categories:

Severity Level 1 Drug-Drug Interaction       Other \_\_\_\_\_

Requested Medication	Strength	Quantity	Dosage Regimen	Diagnosis

Has medication been previously provided?     No     Yes    Date \_\_\_\_\_

Please add a brief summary that would help document the need for the above listed medications.

Clinical Summary: A current plan of treatment and progress notes may be requested for documentation.

**Note: For Severity Level 1 Drug-Drug interactions please provide clinical rationale and monitoring plans for the co-administration of contraindicated drug products. Certain other products (e.g. Synagis) have specific prior authorization forms found at: <http://www.indianamedicaid.com/ihcp/Publications/forms.asp>**


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