

**INDIANA HEALTH COVERAGE PROGRAMS (IHCP) PHARMACY BENEFIT
EARLY REFILL 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 by requesting Prescriber or Pharmacist or the request will be returned****

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

Please select reason for request below:

<p>Retail Pharmacy:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Previous claim has wrong days supply and cannot be reversed/resubmitted <input type="checkbox"/> Change in dosage <input type="checkbox"/> School/work supply for non-transportable items <input type="checkbox"/> Released from hospital, Long Term Care (LTC) facility, or group home <input type="checkbox"/> Vacation/absence from Indiana residence to place outside of Indiana (1 approved request per medication per 365 days) <input type="checkbox"/> Non-controlled medication lost, spilled, or damaged (1 approved request per medication per 365 days) <input type="checkbox"/> Non-controlled medication stolen or destroyed by fire (documentation from law enforcement or insurance must be attached), or destroyed by a natural disaster
<p>Controlled medication: (Requires prescriber's signature, LTC facility requests will be denied)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Medication has been lost or spilled (1 approved request per medication per 365 days) <input type="checkbox"/> Medication has been stolen or destroyed by fire (documentation from law enforcement or insurance must be attached), or destroyed by a natural disaster
<p>LTC Pharmacy: (Controlled and Non-controlled)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Previous claim has wrong days supply and cannot be reversed/resubmitted <input type="checkbox"/> Change in dosage <input type="checkbox"/> New admit or re-admit <input type="checkbox"/> Patient is going on leave of absence <input type="checkbox"/> Patient has a PRN order and a routine order with different prescription numbers

Medication	Quantity	Dosage Regimen

<p>If necessary, add a brief summary that would help document the need for an early refill of the medications listed above.</p>

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