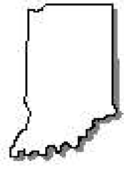
INDIANA HEALTH COVERAGE PROGRAMS (IHCP) PHARMACY BENEFIT
OPIOID WITH CONCURRENT BUPRENORPHINE/NALOXONE OR BUPRENOPRHINE
PRIOR AUTHORIZATION REQUEST FORM



OptumRx
P.O. Box 25184
Santa Ana, CA, 92799
Phone: (866) 215-5046 Fax: (866) 940-7328

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 opiate therapy. Please indicate buprenorphine/naloxone or buprenorphine prescriber's name:____

☐ Opiate therapy prescribed is 7 days or less.

CONFIDENTIAL INFORMATION
This facsimile transmission (and attachments) may contain protected health information from the Indiana Health Coverage Programs (IHCP), which is intended only for the use of the individual or entity named in this transmission sheet. Any unintended recipient is hereby notified that the information is privileged and confidential, and any use, disclosure, or reproduction of this information is prohibited.