CareSource Rxinnovations

INDIANA HEALTH COVERAGE PROGRAMS (IHCP) PHARMACY BENEFIT PRIOR AUTHORIZATION REQUEST FORM BRAND MEDICALLY NECESSARY (BMN) MEDICATION

CareSource Pharmacy Prior Authorization Form
P.O. Box 8738
Dayton, OH 45401-8738
Fax: (866) 930-0019

Today's Date ☐☐ ☐☐ ☐☐☐☐

Non-Urgent ☐ Urgent ☐

Note: This form must be filled out by prescribing provider.

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

Patient's CareSource # ☐☐☐☐☐☐☐☐☐☐☐☐	Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
Patient's Name	Prescriber's Name
Prescriber's IN License # ☐☐☐☐☐☐☐☐	Specialty
Prescriber's NPI # ☐☐☐☐☐☐☐☐☐☐	Office Contact
Prescriber's Fax ☐☐☐ - ☐☐☐ - ☐☐☐☐	Prescriber's Phone ☐☐☐ - ☐☐☐ - ☐☐☐☐
Prescriber's Address	Date(s) of Service:_____ Start Date: _____

Medication for which "brand medically necessary" is being specified	Strength	Quantity	Direction for Use	ICD-10 Diagnosis

Reason for Request of Brand Name:

_____

_____

_____

MedWatch Form Attachment (Required):

Prior authorization is contingent upon your submission to FDA of a completed MedWatch form which describes the adverse event(s) experienced by the patient with a generic equivalent for the brand name drug for which you are specifying "brand medically necessary."

Please attach to this prior authorization request form a photocopy of the MedWatch form you are submitting to FDA.
NOTE: Please do not submit original MedWatch forms to CareSource.

MedWatch forms can be downloaded at the following address:
http://www.fda.gov/downloads/AboutFDA/ReportsManualsForms/Forms/UCM163919.pdf

In accordance with Indiana Medicaid law at 405 IAC 5-24-8(a), prior authorization is required when specifying "brand medically necessary" for substitutable brand name drugs. A few exceptions apply, please contact the Provider Services at the number indicated above for details. Please contact the Provider Services at **1-844-607-2831** if you have questions about this form or require assistance in completing it.

I attest that the provided information above is accurate:

Physician Signature: _____ **Date:** _____