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

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

CareSource RxInnovations

Today's Date ☐☐ / ☐☐ / ☐☐☐☐

Non-Urgent ☐ Urgent ☐

Note: This form must be completed by the prescribing provider.

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

Member's CareSource ID	Member's Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
Member's Name	Prescriber's Name
Prescriber's Indiana License Number	Specialty
Prescriber's NPI	Office Contact
Prescriber's Fax ☐☐☐ - ☐☐☐ - ☐☐☐☐	Prescriber's Phone ☐☐☐ - ☐☐☐ - ☐☐☐☐
Prescriber's Address	Date(s) of Service: Start Date:

Requested Medication	Strength	Quantity	Directions for Use	Diagnosis and ICD-10

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 seven days or less.

If opioid therapy is expected to be used concomitantly with buprenorphine/naloxone or buprenorphine for greater than seven days, please provide a brief explanation as to why opioid therapy is needed for a duration longer than plan permitted limits. Please provide plans regarding expected duration of opioid therapy as well as plans to taper off and discontinue opioid therapy.

_____

I attest that the information provided above is accurate:

Physician Signature: _____ **Date:** _____