CareSource Rxinnovations

INDIANA HEALTH COVERAGE PROGRAMS (IHCP) PHARMACY BENEFIT
MENTAL HEALTH MEDICATIONS MEDICAL NECESSITY REVIEW FORM

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 completed by the 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: _____

Requested Medication	Strength	Qty	Dosage Regimen	Diagnosis and Diagnosis Code	Date Started

Check the applicable prescribing situation and answer questions as specified:

- ☐ 2 or more concurrent antipsychotic agents
- ☐ Antipsychotic use at lower than minimum effective dose
- ☐ 2 or more concurrent sedative hypnotic and/or benzodiazepine agents
- ☐ 2 or more concurrent SSRI or SNRI agents
- ☐ 2 or more concurrent stimulant agents

For any box checked, answer questions **1 – 4** in the "Questions" section below.

Questions:	**Yes**	**No**
1. Is (are) the medication(s) prescribed for a DSM-V diagnosis?	☐	☐
2. Is (are) the medication(s) prescribed by, or in consultation with, a psychiatrist?	☐	☐
3. Is the medication, or one of its counterparts, being tapered/cross-tapered? Anticipated duration of taper:_____	☐	☐
4. Is there documentation in the medical record that the patient has had a trial of each of the medications individually, at adequate dose and duration, and is improving more on the combination than on any one of the medications separately?	☐	☐

Indiana Medicaid Mental Health Quality Advisory Committee

Medical Necessity Review Form

Associated Medication History	Strength	Qty	Dosage Regimen	Diagnosis	Date Started

Clinical Explanation/Justification (please be thorough; a current plan of treatment and progress notes may be requested for documentation; provide information if the medications being requested are replacements for discontinued medications):

I attest that the information provided on this form is accurate:

Physician Signature: _____ Date: _____