Indiana Health Coverage Programs (IHCP) Pharmacy Benefit
Mental Health Medications
Medical Necessity Review Form

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OPTUMRx®

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).

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

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Requested Medication	Strength	Qty	Dosage Regimen	Diagnosis	Date Started

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):

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