

MOUD- Override Request: Grants & Legislative Funds Medication Request

Fax to: 855-571-3002 (Note: 24 hour turn-around time for all requests)

Provider Organization (Select checkbox):

Process for completing this form:

- Provider to enroll member in NTXIX/XXI Enrollment or Crisis State Only Enrollment with Mercy Care RBHA eligibility/enrollment. Member to remain under NTXIX/XXI eligibility unless he/she qualifies for a separate line of business.
- Provider to fax attached request form to Mercy Care RBHA Pharmacy Prior Authorization Unit: Fax (855-571-3002).
- Once member is loaded as eligible in the Mercy Care RBHA NTXIX system, the Pharmacy PA unit will enter an authorization to override the requested MAT medication for the specified duration (max 6 months) that was documented on the fax form submitted

Requesting Provider: _____

Provider NPI: _____

Organization Address: _____

Organization Phone Number: _____

Fax Number: _____

Member Name: _____

Member ID: _____

Member DOB: _____

Requested Medication (Select checkbox next to drug and provide strength and quantity requested):

<table border="0" style="width: 100%;"> <tr> <td style="width: 80%;"></td> <td style="text-align: center;">Strength/Quantity:</td> </tr> <tr> <td><input type="checkbox"/> Acamprosate Calcium DR Tablet:</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Disulfiram Tablet:</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Naltrexone Tablet:</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Vivitrol IM Suspension:</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Clonazepam:</td> <td>_____</td> </tr> </table>		Strength/Quantity:	<input type="checkbox"/> Acamprosate Calcium DR Tablet:	_____	<input type="checkbox"/> Disulfiram Tablet:	_____	<input type="checkbox"/> Naltrexone Tablet:	_____	<input type="checkbox"/> Vivitrol IM Suspension:	_____	<input type="checkbox"/> Clonazepam:	_____	<table border="0" style="width: 100%;"> <tr> <td style="width: 80%;"></td> <td style="text-align: center;">Strength/Quantity:</td> </tr> <tr> <td><input type="checkbox"/> Phenobarbital:</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Buprenorphine/Naloxone SL Tablet:</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Buprenorphine SL Tablet:</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Naltrexone Tablet:</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Naloxone Vial/Syringe/Nasal Spray:</td> <td>_____</td> </tr> </table>		Strength/Quantity:	<input type="checkbox"/> Phenobarbital:	_____	<input type="checkbox"/> Buprenorphine/Naloxone SL Tablet:	_____	<input type="checkbox"/> Buprenorphine SL Tablet:	_____	<input type="checkbox"/> Naltrexone Tablet:	_____	<input type="checkbox"/> Naloxone Vial/Syringe/Nasal Spray:	_____
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Supportive medications:

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Is the member pregnant/breastfeeding: Yes No

Requested Duration (max 6 months): _____

Additional Notes:

****Notes to Tech—work up request and close as tech approval. Enter override for requested medication/duration (not to exceed 6 months) and ensure test claim pays****