mercy care

MOUD-Override Request: Grants & Legislative Funds

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

Provider Organization (*choose from dropdown*):

- BAART

Process for completing this form:

- Provider to enroll member in NTXIX/XXI or Crisis State Only segment 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: _____

Member Name: _____ **Member ID: _____**

Member DOB: _____

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

	Strength/Quantity:		Strength/Quantity:
☐Acamprosate Calcium DR Tablet:		☐Brixadi (PA required)*:	
☐Disulfiram Tablet:		☐Buprenorphine SL Tablet:	
☐Naltrexone Tablet:		☐Naltrexone Tablet:	
☐Vivitrol IM Suspension:		☐Naloxone Vial/Syringe/Nasal Spray:	
☐Clonazepam:		☐Sublocade (PA required)*:	
☐Phenobarbital:			
☐Buprenorphine/Naloxone SL Tablet:			

**Requests for Sublocade and Brixadi MUST be submitted with the Sublocade-Brixadi Pharmacy Prior Authorization Form available at* https://www.mercycareaz.org/providers/rbha-forproviders/pharmacy

Supportive medications:

	Strength/Quantity:		Strength/Quantity:
☐Carbamazepine Tablet:		☐Ibuprofen Tablet:	
☐Clonidine Tablet:		☐Loperamide Capsule/Tablet:	
☐Diphenhydramine Capsule/Tablet:		☐Ondansetron Tablet:	
☐Divalproex Sodium:		☐Trazodone Immediate Release:	
☐Folic Acid:		☐Vitamin B6 (Pyridoxine):	
☐Gabapentin Capsule:		☐Vitamin B1 (Thiamine):	

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