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*):

- Choose an item.

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:
☐Acamprosate Calcium DR Tablet:	
☐Disulfiram Tablet:	
☐Naltrexone Tablet:	
☐Vivitrol IM Suspension:	
☐Clonazepam:	
☐Phenobarbital:	
☐Buprenorphine/Naloxone SL Tablet:	

	Strength/Quantity:
☐Buprenorphine SL Tablet:	
☐Naltrexone Tablet:	
☐Naloxone Vial/Syringe/Nasal Spray:	
☐Sublocade (PA required)*:	

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

Supportive medications:

	Strength/Quantity:
☐Carbamazepine Tablet:	
☐Clonidine Tablet:	
☐Diphenhydramine Capsule/Tablet:	
☐Divalproex Sodium:	
☐Folic Acid:	
☐Gabapentin Capsule:	

	Strength/Quantity:
☐Ibuprofen Tablet:	
☐Loperamide Capsule/Tablet:	
☐Ondansetron Tablet:	
☐Trazodone Immediate Release:	
☐Vitamin B6 (Pyridoxine):	
☐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

Effective: 09/08/2022