

Iowa Department of Human Services

Request for Prior Authorization

NONSTEROIDAL ANTI-INFLAMMATORY DRUGS

FAX Completed Form To 1 (800) 574-2515

Provider Help Desk 1 (877) 776-1567

(PLEASE PRINT - ACCURACY IS IMPORTANT)

| (FLEASE FRINT - ACCURACT IS IMPORTANT) | | | | | | |
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| IA Medicaid Member ID # | | Patient name | | | DOB | |
| Patient address | | | | | | |
| Provider NPI | | Prescriber na | me | | Phone | |
| Prescriber address | | | | Fax | | |
| Pharmacy name | | Address | | | Phone | |
| Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned. | | | | | | |
| Pharmacy NPI | | Pharmacy fax | | NDC | | |
| not required for preferred nsaids or COX-2 inhibitors. 1. Requests for a non-preferred nsaid must document previous trials and therapy failures with at least three preferred nsaids. 2. Requests for a non-preferred COX-2 inhibitor must document previous trials and therapy failures with three preferred nsaids, two of which must be preferred COX-2 preferentially selective nsaids. 3) Requests for a non-preferred topical nsaid must document previous trials and therapy failures with three preferred nsaids. The trials must include two preferred COX-2 preferentially selective nsaids and the oral drug of the same chemical entity. In addition, the use of a topical delivery system must be deemed medically necessary. 4) Requests for a non-preferred extended release nsaid must document previous trials and therapy failures with three preferred nsaids, one of which must be the preferred immediate release nsaid of the same chemical entity at a therapeutic dose that resulted in a partial response with a documented intolerance. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated. | | | | | | |
| Preferred (No PA required) Non-Preferred (PA required for all products) | | | | | | |
| Diclofenac Sod./Pot. Diclofenac Sod. EC/DR Etodolac 400mg/500mg Flurbiprofen Ibuprofen Ibuprofen Susp. Indomethacin Ketoprofen | Nabumet Naprosyr Naproxer Naproxer | n EC/ER n Sodium 550mg | ☐ Arthrotec ☐ Celebrex ☐ Celecoxib ☐ Diclofenac ER/XR* ☐ EC-Naprosyn ☐ Etodollac CR/ER/XR ☐ Fenoprofen ☐ Flector Patch ☐ Other (specify) | ☐ Naprelan ☐ Oxaprosi | en ER amate Sod n | Tivorbex Tolmetin Sod Vivlodex Voltaren Gel Voltaren XR Zipsor Zorvolex |
| Strength | Dosage I | nstructions | | Quantity | Days | Supply |
| Diagnosis: Preferred Drug Trial 1: Drug Name& Dose | | | | | | |
| Failure Reason | | | | | | |
| Preferred Drug Trial 2: Drug Name& Dose Trial Dates: | | | | | | |
| Preferred Drug Trial 3: Drug Name& Dose | | | | Trial Dates: | | |
| Failure Reason | | | | | | |
| Medical Necessity for alternative delivery system: | | | | | | |
| Medical or contraindication reason to override trial requirements: | | | | | | |
| Reason for use of Non-Preferred drug requiring prior approval: | | | | | | |
| Prescriber signature (Must match prescriber listed above.) | | | | Date of submission | | |

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.