



Request for Prior Authorization Duplicate Therapy Edit Override

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

A prior authorization is required for duplicate therapy for designated therapeutic classes.

Medications:

Four rows of medication information fields including Drug name & strength, Quantity, Days supply, Dosing instructions, and Date therapy initiated.

Diagnosis:

Medical necessity for concurrent therapy:

Anticipated length of concurrent therapy:

Proposed drug tapering schedule (if applicable):

Reason for use of non-preferred drug requiring prior approval:

Other medical conditions to consider:

Attach lab results and other documentation as necessary.

Form with fields for Prescriber signature (Must match prescriber listed above.) and 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.