

Iowa Department of Human Services

FAX Completed Form To 1 (800) 574-2515

Provider Help Desk 1 (877) 776-1567

Request for Prior Authorization New-to-Market Drugs

	(PLEASE PRINT - ACCURACY I	S IMPORTA	ANT)	
IA Medicaid Member ID #	Patient name			DOB
Patient address				
Provider NPI	Prescriber name			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	N	IDC	
 Prior authorization is required for new-to-market drugs not yet reviewed by the Iowa Medicaid Pharmaceutical & Therapeutics (P&T) Committee. Payment will be considered for patients when the following criteria are met: Patient has an FDA approved or compendia indication for the requested drug; and If the requested drug falls in a therapeutic category/class with existing prior authorization criteria, the requested drug must meet the criteria for the same indication; or If no clinical criteria are established for the requested drug, patient has tried and failed at least two preferred drugs, when available, from the Iowa Medicaid Preferred Drug List (PDL) for the submitted indication; and Request must adhere to all FDA approved labeling. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated. 				
Once new-to-market drugs are reviewed by the P&T Committee, they will be placed on the PDL which will dictate ongoing PA criteria, if applicable.				
Drug name:		Strength:		
Dosage instructions:		Quantity:_		Day's supply:
Preferred Drug Trial 1: Drug name/dose:				
Trial start date:Reason for failure:		Trial end date:		
Preferred Drug Trial 2: Drug name/dose:				
Trial start date: Trial e			nd date:	
Reason for failure:				
Pertinent lab data:				
Other medical conditions to consider:				
Other relevant information:				
Possible drug interactions/conflicting drug therapies:				
Attach lab results and other documentation as necessary.				
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.

470-5492 (10/17)