



Request for Prior Authorization
BENZODIAZEPINES

(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.

Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.

Prior authorization is required for non-preferred benzodiazepines. Payment for non-preferred benzodiazepines will be authorized in cases with documentation of previous trial and therapy failure with two preferred products.

Preferred

- Alprazolam, Chlordiazepoxide, Clobazam, Clonazepam, Clorazepate, Diazepam, Estazolam, Flurazepam, Lorazepam, Oxazepam, Temazepam 15 & 30mg

Non-Preferred

- Ativan, Alprazolam ER, Alprazolam ODT, Clonazepam ODT, Dalmane, Doral, Halcion, Klonopin, Klonopin Wafers, Librium, Onfi, Restoril, Sympazan, Temazepam 7.5/22.5mg, Tranzone, Triazolam, Xanax, Xanax XR

Other (specify) \_\_\_\_\_

Strength Dosage Instructions Quantity Days Supply

Diagnosis:

- Generalized anxiety disorder, Panic attack with or without agoraphobia, Seizure, Other (please specify), Non-progressive motor disorder, Dystonia

Trial 1 with preferred agent: Drug Name Strength Dosage instructions Trial Date from Trial Date to

Trial 2 with preferred agent: Drug Name Strength Dosage instructions Trial Date from Trial Date to

Prescriber review of patient's controlled substances use on the Iowa PMP website:

No Yes Date Reviewed:

Is benzodiazepine use appropriate for patient based on PMP review? No Yes



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Patients taking concurrent opioids:

Have the risks of using opioids and benzodiazepines concurrently been discussed with the patient? [ ] No [ ] Yes

Medical necessity for concurrent use: \_\_\_\_\_

Provide plan to taper the opioid or benzodiazepine or medical rationale why not appropriate: \_\_\_\_\_

Medical or contraindication reason to override trial requirements: \_\_\_\_\_

Reason for use of Non-Preferred drug requiring prior approval: \_\_\_\_\_

Attach lab results and other documentation as necessary.

Table with 2 columns: 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.