



Request for Prior Authorization

FAX Completed Form To

I (800) 574-2515

MODIFIED FORMULATIONS

Provider Help Desk

I (877) 776-1567

(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.

Payment for a non-preferred isomer, prodrug or metabolite will be considered when the following criteria are met: 1) Previous trial with a preferred parent drug of the same chemical entity at a therapeutic dose that resulted in a partial response with a documented intolerance and 2) Previous trial and therapy failure at a therapeutic dose with a preferred drug of a different chemical entity indicated to treat the submitted diagnosis if available. The required trials may be overridden when documented evidence is provided that the use of these preferred agent(s) would be medically contraindicated.

- Horizontal checkboxes for Horizant (gabapentin), Trilipix (Tricor), Xopenex HFA (albuterol HFA), Xopenex Nebs (albuterol nebs).

Payment for a non-preferred alternative delivery system will only be considered for cases in which the use of an alternative delivery system is medically necessary and there is a previous trial and therapy failure with a preferred alternative delivery system as noted in ( ).

- Vertical checkboxes for various drugs: Abilify Discmelt, Adlarity, Alkindi, Aricept ODT, Aspruzo, Atorvaliq, Binosto, Clozapine ODT / Fazacllo, Dartisla, Drizalma, Elyxyb, Eprontia, Exservan, Ezallor, Gimoti, Lamotrigine ODT, Metoclopramide ODT, Norliqva, Remeron SolTab, Risperidone ODT, Sertraline Caps, Sitavig, Spritam, Sympazan, Tramadol Oral Solution, Zyprexa Zydis.

Strength: Dosage Instructions: Quantity: Days Supply:

Diagnosis:

Trial with parent drug product: Drug Name & Dose: Trial dates:

Failure Reason:

Trial with drug of a different chemical entity: Drug Name & Dose: Trial dates:

Failure Reason:

Medical Necessity for alternative delivery system:

Failure Reason of preferred alternative delivery system:

Medical or contraindication reason to override trial requirements:

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 Health and Human Services, that the member continues to be eligible for Medicaid.