Iowa Medicaid
IOWA HHS

Request for Prior Authorization
BENZODIAZEPINES

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

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	NDC

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. Prior authorization will be approved for up to 12 months for certain documented diagnoses and a 3 month period for all other diagnoses. If a long-acting medication is requested, one of the therapeutic trials must include the immediate release form of the requested benzodiazepine. The prescriber must review the patient's use of controlled substances on the Iowa Prescription Monitoring Program website and determine if the use of a benzodiazepine is appropriate for this member. For patients taking concurrent opioids, the prescriber must document the following: 1) The risks of using opioids and benzodiazepines concurrently has been discussed with the patient. 2) Documentation as to why concurrent use is medically necessary is provided. 3) A plan to taper the opioid or benzodiazepine is provided, if appropriate. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Preferred

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

Non-Preferred

- ☐ Ativan
- ☐ Alprazolam ER
- ☐ Alprazolam ODT
- ☐ Clonazepam ODT
- ☐ Dalmane
- ☐ Halcion
- ☐ Klonopin
- ☐ Klonopin Wafers
- ☐ Librium
- ☐ Loreev XR
- ☐ Onfi
- ☐ Restoril
- ☐ Sympazan
- ☐ Temazepam 7.5/22.5mg
- ☐ Tranzene
- ☐ 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.

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.*