



## Request for Prior Authorization BENZODIAZEPINES

FAX Completed Form To 1.833.404.2392

Pharmacy Help Desk 1.800.460.8988

**Prescriber Help Desk** 

(PLEASE PRINT – ACCURACY IS IMPORTANT) 1.833.587.2012

IA Medicaid Member ID #	Patient name			DOB	
Patient address					
Provider NPI	Prescriber na	me		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  Prior authorization is required for no	Pharmacy fax		NDC		
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 lowa 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 Estazolai Chlordiazepoxide Flurazepa Clobazam Coxazepam Oxazepa Clorazepate Temazepa Diazepam	m	Alprazolam ER	lonopin lonopin Wafer ibrium enfi estoril ympazan ner (specify)_	☐ Temazepam 7.5/22.5mg rs ☐ Tranzene ☐ Triazolam ☐ Xanax ☐ Xanax XR	
Strength	Dosage Instruction	ons Quantity	Days Տսլ	oply	
Diagnosis:  Generalized anxiety disor Panic attack with or without Seizure Other (please specify)	out agoraphobia	•	ve motor dis	- order	
Trial 1 with preferred agent: Drug	Name		Strength	1	
Dosage instructions		Trial Date from	Tria	al Date to	
Trial 2 with preferred agent: Drug	Name		Strength	1	
Dosage instructions					
Prescriber review of patient's controlled substances use on the lowa 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 app	oropriate:
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.

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