



Request for Prior Authorization MODIFIED FORMULATIONS

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Fax Completed Form To
 1.833.404.2392
Prescriber Help Desk
 1.833.587.2012
Online
[covermymeds.com/main/
prior-authorization-forms/](http://covermymeds.com/main/prior-authorization-forms/)

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

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.

<input type="checkbox"/> Horzant (trial of gabapentin) <input type="checkbox"/> Trilipix (trial of Tricor)	<input type="checkbox"/> Xopenex HFA / levalbuterol tartrate (trial of albuterol HFA)
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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 ().

<input type="checkbox"/> Adlarity (donepezil tabs) <input type="checkbox"/> Alkindi (hydrocortisone tabs) <input type="checkbox"/> Aspruzyo (ranolazine tabs) <input type="checkbox"/> Atorvaliq (atorvastatin tabs) <input type="checkbox"/> Binosto (alendronate tabs) <input type="checkbox"/> Clozapine ODT (clozapine tabs) <input type="checkbox"/> Dartisia (glycopyrrolate tabs) <input type="checkbox"/> Donepezil ODT (donepezil tabs) <input type="checkbox"/> Drizalma (duloxetine caps) <input type="checkbox"/> Elyxyb (celecoxib caps) <input type="checkbox"/> Entresto Sprinkle Caps (Entresto tabs) <input type="checkbox"/> Eprontia / Topiramate Oral Solution (topiramate tabs) <input type="checkbox"/> Ezallor (rosuvastatin tabs)	<input type="checkbox"/> Gimoti (metoclopramide tabs) <input type="checkbox"/> Lamotrigine ODT (lamotrigine chew tabs) <input type="checkbox"/> Likmez (metronidazole tabs) <input type="checkbox"/> Metoclopramide ODT (metoclopramide soln) <input type="checkbox"/> Norliqva (amlodipine tabs) <input type="checkbox"/> Remeron SolTab (mirtazapine tabs) <input type="checkbox"/> Risperidone ODT (risperidone soln) <input type="checkbox"/> Sertraline Caps (sertraline tabs) <input type="checkbox"/> Sitavig (acyclovir oral susp) <input type="checkbox"/> Spritam / Levetiracetam ODT (levetiracetam soln) <input type="checkbox"/> Sympazan (clobazam susp) <input type="checkbox"/> Valsartan Oral Solution (valsartan tabs) <input type="checkbox"/> Zyprexa Zydis (Zyprexa tabs)
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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.

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