FAX Completed Form To
1.877.386.4695

Provider Help Desk
1.866.399.0928

Request for Prior Authorization
MODIFIED FORMULATIONS

(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

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.

☐ Horizant (trial of gabapentin) ☐ Invega / Paliperidone ER (trial of risperidone) ☐ Trilipix (trial of Tricor)

☐ Xopenex HFA / levalbuterol tartrate (trial of albuterol HFA) ☐ Xopenex Nebs / levalbuterol nebs (trial of 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 ( ).

☐ Abilify Discmelt (Abilify soln) ☐ Aricept ODT (Aricept tabs) ☐ Baqsimi (Glucagen) ☐ Binosto (alendronate tabs)

☐ Clozapine ODT / Fazaclo (clozapine tabs) ☐ Drizalma (duloxetine caps) ☐ Ezallor (rosuvastatin tabs)

☐ Lamotrigine ODT (lamotrigine chew tabs) ☐ Metoclopramide ODT (metoclopramide soln) ☐ Remeron SolTab (mirtazapine tabs)

☐ Remeron SolTab (mirtazapine tabs) ☐ Risperdal M-Tab (risperidone soln) ☐ Sitavig (acyclovir oral susp)

☐ Spritam (levetiracetam soln) ☐ Sympazan (clobazam susp) ☐ Zyprexa Zydis (Zyprexa tabs)

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

Rev. 10/20