iowa total care | Iowa Health Link Iowa HHS | Hawki Iowa HHS

Fax Completed Form To
1.833.404.2392
Prescriber Help Desk
1.833.587.2012
Online
covermymeds.com/main/prior-authorization-forms/

Request for Prior Authorization
BENZODIAZEPINES
(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
- ☐ Clonazepam ODT
- ☐ Clorazepate
- ☐ Diazepam
- ☐ Estazolam
- ☐ Lorazepam
- ☐ Oxazepam
- ☐ Temazepam 15/30mg

Non-Preferred
- ☐ Ativan
- ☐ Alprazolam ER
- ☐ Alprazolam ODT
- ☐ Halcion
- ☐ Klonopin
- ☐ Loreev XR
- ☐ Onfi
- ☐ Restoril
- ☐ Sympazan
- ☐ Temazepam 7.5/22.5mg
- ☐ 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: _____

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Is benzodiazepine use appropriate for patient based on PMP review? ☐ No ☐ Yes

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