iowa total care | ia health link | Hawki

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

New-to-Market Drugs

(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 new-to-market drugs not yet reviewed by the Iowa Medicaid Pharmaceutical & Therapeutics (P&T) Committee. Payment will be considered for patients when the following criteria are met:

1) Patient has an FDA approved or compendia indication for the requested drug; and
2) If the requested drug falls in a therapeutic category/class with existing prior authorization criteria, the requested drug must meet the criteria for the same indication; or
3) If no clinical criteria are established for the requested drug, patient has tried and failed at least two preferred drugs, when available, from the Iowa Medicaid Preferred Drug List (PDL) for the submitted indication; and
4) Request must adhere to all FDA approved labeling.

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Once new-to-market drugs are reviewed by the P&T Committee, they will be placed on the PDL which will dictate ongoing PA criteria, if applicable.

Drug name:_____ Strength:_____

Dosage instructions:_____ Quantity:_____ Day's supply:_____

Diagnosis:_____

Preferred Drug Trial 1: Drug name/dose:_____

Trial start date: _____ Trial end date: _____

Reason for failure: _____

Preferred Drug Trial 2: Drug name/dose:_____

Trial start date: _____ Trial end date: _____

Reason for failure: _____

Pertinent lab data:_____

Other medical conditions to consider:_____

_____

Other relevant information:_____

Possible drug interactions/conflicting drug therapies:_____

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.*