

**REQUEST FOR PRIOR AUTHORIZATION
NON-PREFERRED DRUG**
(PLEASE PRINT - ACCURACY IS IMPORTANT)

Online
covermy meds.com/main/prior-authorization-forms/

IA Medicaid	
Member ID #: <input type="text"/>	Patient Name: <input type="text"/> DOB: <input type="text"/>
Patient Address: <input type="text"/>	
Provider NPI: <input type="text"/>	Prescriber Name: <input type="text"/> Phone: <input type="text"/>
Prescriber Address: <input type="text"/> Fax: <input type="text"/>	
Pharmacy Name: <input type="text"/>	Address: <input type="text"/> Phone: <input type="text"/>
Prescriber must fill all information above. It must be legible, correct and complete or form will be returned.	
Pharmacy	
NPI: <input type="text"/>	Pharmacy Fax: <input type="text"/> NDC : <input type="text"/>

Prior authorization is required for non-preferred drugs as specified on the Iowa Medicaid Preferred Drug List. Payment for a non-preferred medication will be authorized only for cases in which there is documentation of previous trial and therapy failure with the preferred agent, unless evidence is provided that use of these agents would be medically contraindicated. * Please refer to the Selected Brand-Name Drugs prior authorization form if requesting a non-preferred brand-name product.

Drug Name: **Strength:**

Dosage Instructions: **Quantity:** **Days Supply:**

Diagnosis:

Previous therapy (include drug name(s), strength and exact date ranges):

Reason for use of Non-Preferred drug requiring prior approval:

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: **Date of Submission:**

*MUST MATCH PRESCRIBER LISTED ABOVE

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.