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
# SELECT ONCOLOGY AGENTS

(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 select oncology agents. Patient must have a diagnosis that is indicated in the FDA-approved package insert or the use is for an indication supported by the compendia (including National Comprehensive Cancer Network (NCCN) compendium level of evidence 1, 2A, or 2B). The following must be submitted with the prior authorization request: copies of medical records (i.e., diagnostic evaluations and recent chart notes); location of treatment (provider office, facility, home health, etc.); if medication requested is not an oral agent, the original prescription; and the most recent copies of related laboratory results. If criteria for coverage are met, initial authorization will be given for three (3) months. Additional authorizations will be considered for up to six (6) month intervals when criteria for coverage are met. Updates on disease progression must be provided with each renewal request. If disease progression is noted, therapy will not be continued unless otherwise justified.**

**Provider specialty:** _____

**Patient information:** Height:_____ (in) _____ (cm) Weight:_____ (lb) _____ (kg) BSA:_____

**Diagnosis:** _____

**Medication requested:** ☐ New ☐ Continuation

| Medication | Strength | Dosage Instructions | # of Cycles | Quantity | Days Supply |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

**Previous treatment trials:**

| Medication | Strength | Dosage Instructions | # of Cycles | Quantity | Days Supply |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Attach copies of the following:**

☐ Medical records (i.e., diagnostic evaluations and recent chart notes)
☐ Original prescription
☐ Recent related laboratory results

**Please indicate setting in which medication is to be administered if medication requested is not an oral agent:**

☐ Home by home health ☐ Long-term care facility ☐ Other:_____

**Renewal requests: Has disease progressed?** ☐ Yes ☐ No Date of last office visit:_____

| 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.*