

**Request for Prior Authorization
SELECTED BRAND NAME 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 fill 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 selected brand-name drugs, as determined by the Department, for which there is available an “A” rated bioequivalent generic product as determined by the Federal Food and Drug Administration, unless the brand drug has been designated by the Department as preferred (payable) under the Iowa Medicaid Preferred Drug List (PDL). For prior authorization to be considered, the prescriber must submit a completed Selected Brand-Name Drugs PA form and Iowa Medicaid MedWatch form with:

1. Documentation of trials and therapy failures with two different generic manufacturers of the same chemical entity. If an allergy to an inactive component is suspected, the second trial must be with a generic product that does not contain the allergen, if available.
2. Documentation of the failure must include the specific adverse reaction as defined by the FDA (See Section B of the MedWatch form). Intolerances, such as nausea or vomiting, to the generic drug will not be considered as a basis for approval.

Trials may be overridden when evidence is provided that use of the generic product would be medically contraindicated.

Drug Name: _____ Strength: _____

Dosage Instructions: _____ Quantity: _____ Days Supply: _____

Diagnosis: _____

Previous therapy (include drug name(s), manufacturer/labeler, strength, exact date ranges, and specific failure reason):* **To be documented on MedWatch form**

Other relevant information: _____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission
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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.

**Request for Prior Authorization
 SELECTED BRAND NAME DRUGS
 Iowa Medicaid MedWatch Form**

Revised for submission of brand medically necessary requests for the Iowa Medicaid Pharmacy Program. Prescriber must have witnessed or has documentation that the manifestation of adverse event(s) is linked to generic drug. Completion of form does not automatically grant approval; incomplete forms will be returned with denial.***

A. PATIENT INFORMATION

Name: _____ Sex: F M
 Medicaid ID: _____ DOB: ____/____/____
 Weight: _____ lbs Phone: (____) _____
 Has a generic been tried before? Yes No
 Give date: ____/____/____ Age at time of event: _____

8. NDC # (specify generic manufacturer
 #1 _____
 #2 _____

B. ADVERSE EVENT, PRODUCT PROBLEM

1. Check all that apply
 Adverse Event
 Product Use Error
 Product Problem (e.g., defects/malfunctions)
 Problem with Different Manufacturer of Same Medicine
2. Outcomes Attributed to Adverse Event: (Check all that apply.)
 Death: _____ (month/day/year)
 Disability or Permanent Damage
 Life-threatening
 Congenital Anomaly/ Birth Defects
 Required Intervention to Prevent Permanent Impairment/Damage
 Hospitalization – Initial or Prolonged
 Other Serious (Important Medical Events)

3. Date of Event (mo/day/yr) _____ 4. Date of This Report (mo/day/yr) _____

5. Describe Event, Problem, or Product Use Error; Relevant History & Tests

D. OTHER (CONCOMITANT) MEDICAL PRODUCTS

Product names and therapy dates (exclude treatment of event).

E. REPORTER CERTIFICATION

Signature certifies that brand is medically necessary

Prescriber's Name _____

Signature _____ NPI # _____

Address: _____

Phone #: (____) _____ - _____

Fax #: (____) _____ - _____

Did the prescriber witness the ADR? Yes No
 Has the ADR been previously reported to the FDA? Yes No

**Please FAX form to
 Iowa Total Care at 1.833.404.2392
 DO NOT fax directly to the FDA**

C. SUSPECT MEDICATIONS

1. Name (Give labeled strength & mfr/labeler, if known)
 #1 _____
 #2 _____

2. Dose, Frequency & Route Used
 #1 _____
 #2 _____

3. Therapy Dates
 #1 _____
 #2 _____

4. Diagnosis for Use (Indication)
 #1 _____
 #2 _____

5. Event Abated After Use
 Stopped or Dose Reduced?
 #1 Yes No N/A
 #2 Yes No N/A

6. Lot # (if known)
 #1 _____
 #2 _____

7. Event Reappeared After Reintroduction
 #1 Yes No N/A
 #2 Yes No N/A