Provider Help Desk
1 (844) 236-1464

Iowa Department of Human Services
Request for Prior Authorization
NALOXONE NASAL SPRAY

(PLEASE PRINT – ACCURACY IS IMPORTANT)

FAX Completed Form To
1 (877) 733-3195

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 a patient requiring more than 2 doses of naloxone nasal spray per 365 days. Requests for quantities greater than 2 doses per 365 days will be considered under the following conditions: 1) Documentation is provided indicating why patient needs additional doses of naloxone nasal spray (accidental overdose, intentional overdose, other reason); and 2) Naloxone nasal spray is to be used solely for the patient it is prescribed for; and 3) The patient is receiving an opioid as verified in pharmacy claims; and 4) Patient has been reeducated on opioid overdose prevention; and 5) Documentation is provided on the steps taken to decrease the chance of opioid overdose again; and 6) A treatment plan is included documenting a plan to lower the opioid dose.

Preferred

☐ Kloxxado ☐ Narcan ☐ Naloxone (labeler 00781)

Dosing instructions:____________________ Quantity:________ Days supply:____________

Most recent fill date:____________________ Most recent date medication used:____________________

Medical Necessity for Exceeding Quantity Limit:
☐ Intentional overdose ☐ Accidental overdose ☐ Other reason:____________________

Will naloxone nasal spray be used solely for the patient it is prescribed for? ☐ Yes ☐ No

Is patient currently receiving an opioid as verified in pharmacy claims?
☐ No ☐ Yes, provide drug name and most current fill date:____________________

Has patient been reeducated on opioid overdose prevention?
☐ No ☐ Yes, date provided:____________________

Provide documentation on the steps taken to decrease the chance of opioid overdose again:__________

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Provide treatment plan to lower opioid dose:____________________________________

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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.*