MOLINA HEALTHCARE

Iowa Department of Human Services

Request for Prior Authorization
NON-PREFERRED DRUG

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Iowa Health Link
IOWA HHS

Hawki
Iowa HHS

FAX Completed Form To
1 (877) 733-3195
IOWA Provider Services
1 (844) 236-1464

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 (PA) is required for non-preferred drugs as specified on the Iowa Medicaid Preferred Drug List. Payment for a non-preferred medication will be considered for an FDA approved or compendia indicated diagnosis only for cases in which there is documentation of previous trial and therapy failure with the preferred agent(s), 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. Request must adhere to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations.

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 (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.*