AmeriHealth Caritas Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization
Anti-Diabetic Non-insulin Agents

Form applies to IA Health Link and ***hawk-i*** plans.

Please print – accuracy is important.

Fax completed form to 1-855-825-2714. Provider Help Desk: 1-855-328-1612.

AmeriHealth Caritas Iowa member ID #:		Patient name:	
Patient address:			DOB:
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 preferred anti-diabetic, non-insulin agents subject to clinical criteria. Payment will be considered under the following conditions: 1) A diagnosis of type 2 diabetes mellitus, and 2) Patient is 18 years of age or older; and 3) The patient has not achieved HgbA1C goals after a minimum three-month trial with metformin at a maximally tolerated dose, unless evidence is provided that use of this agent would be medically contraindicated. Payment for a non-preferred anti-diabetic, non-insulin agent subject to clinical criteria will be authorized only for cases in which there is documentation of previous trials and therapy failures with metformin, a preferred DPP-4 Inhibitor or DPP-4 Inhibitor combination and a preferred Incretin Mimetic at maximally tolerated doses, unless evidence is provided that use of these agents would be medically contraindicated. Initial authorizations will be approved for six months. Additional prior authorizations will be considered on an individual basis after review of medical necessity and documented continued improvement in HgbA1C.

Please note: AmeriHealth Caritas Iowa uses Iowa Medicaid Enterprise criteria. For complete criteria, please consult www.iowamedicaidpdl.com/pa_criteria.

Preferred DPP-4 Inhibitors and Combinations		Non-Preferred DPP-4 Inhibitors and Combinations	
☐ Janumet	☐ Jentadueto	☐ Alogliptin	☐ Kazano
☐ Janumet XR	☐ Tradjenta	☐ Alogliptin-Metformin	☐ Kombiglyze XR
☐ Januvia		☐ Alogliptin-Pioglitazone	☐ Nesina
		☐ Glyxambi	☐ Onglyza
		☐ Jentadueto XR	☐ Oseni

Preferred incretin mimetics		Non-preferred incretin mimetics	
☐ Byetta		☐ Adlyxin	☐ Trulicity
☐ Tanzeum		☐ Bydureon	☐ Victoza

Non-preferred SGLT2 inhibitors and combinations			
☐ Farxiga	☐ Jardiance	☐ Invokana	☐ Invokamet XR
☐ Synjardy	☐ Xigduo XR	☐ Invokamet	

Strength:	Dosage instructions:	Quantity:	Days supply:
Diagnosis:			
Metformin trial:	Trial start date:	Trial end date:	Trial dose:

Reason for failure:

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Medical or contraindication reason to override trial requirements:

Most recent HgbA1C level: Date this level was obtained:

Requests for non-preferred drugs:

DPP-4 trial: Drug name/dose:

Trial start date: Trial end date:

Reason for failure:

Incretin mimetic trial: Drug name/dose:

Trial start date: Trial end date:

Reason for failure:

Reason for use of non-preferred drug requiring prior approval:

Attach lab results and other documentation as necessary.

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste, and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further attest that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.	
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.

Check www.amerihealthcaritasia.com/Provider to confirm your version of this form.