AmeriHealth Caritas Iowa
Request for Prior Authorization
Antifungal Drugs

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 not required for preferred oral antifungal therapy for a cumulative 90 days of therapy per 12-month period per patient. Prior authorization is required for all non-preferred oral antifungal therapy as indicated on the Iowa Medicaid Preferred Drug List beginning the first day of therapy. Payment for a non-preferred oral antifungal will be authorized only for cases in which there is documentation of previous trial(s) and therapy failure with a preferred agent(s). Payment for any oral antifungal therapy beyond this limit will be authorized in cases where the patient has a diagnosis of an immunocompromised condition or a systemic fungal infection. This prior authorization requirement does not apply to nystatin.

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

Preferred (PA required after 90 days)

☐ Clotrimazole Troche
☐ Fluconazole
☐ Griseofulvin Suspension
☐ Terbinafine
☐ Voriconazole

Non-Preferred (PA required from Day 1)

☐ Cresemba
☐ Diflucan
☐ Grifulvin V
☐ Gris-Peg
☐ Griseofulvin Tablets
☐ Ketoconazole Tablets
☐ Lamisil
☐ Noxafil
☐ Onmel
☐ Oravig
☐ Sporanox
☐ Vfend

Strength: Dosage Instructions: Quantity: Days Supply:

Diagnosis:

Does the patient have an immunocompromised condition? ☐ Yes ☐ No
If yes, diagnosis:

Does the patient have a systemic fungal infection? ☐ Yes ☐ No If yes, date of diagnosis:

Type of infection:

Previous trial(s) with preferred drug(s): Drug Name:

Strength: Trial date from: Trial date to:

Medical or contraindication reason to override trial requirements:

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

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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.