AmeriHealth Caritas
Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization

Benzodiazepines

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 non-preferred benzodiazepines. Requests must document a previous trial and therapy failure with two preferred products. Requests for clobazam (Onfi) will be considered for a diagnosis of seizures associated with Lennox-Gastaut syndrome (LGS) in patients 2 years of age or older when used as an adjunctive treatment. Prior authorization will be approved for up to 12 months for certain documented diagnoses and a 3 month period for all other diagnoses. If a long-acting medication is requested, one of the therapeutic trials must include the immediate release form of the requested benzodiazepine.

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

Preferred:

- ☐ Alprazolam
- ☐ Chlordiazepoxide
- ☐ Clonazepam
- ☐ Clorazepate 7.5mg
- ☐ Clorazepate 15mg
- ☐ Diazepam
- ☐ Estazolam
- ☐ Flurazepam
- ☐ Lorazepam
- ☐ Oxazepam
- ☐ Temazepam 15 and 30mg

Non-Preferred:

- ☐ Ativan
- ☐ Alprazolam ER
- ☐ Alprazolam ODT
- ☐ Clonazepam ODT
- ☐ Clorazepate
- ☐ Dalmane
- ☐ Doral
- ☐ Halcion
- ☐ Klonopin
- ☐ Klonopin Wafers
- ☐ Librium
- ☐ Onfi
- ☐ Prosom
- ☐ Restoril
- ☐ Serax
- ☐ Temazepam 7.5 and 22.5mg
- ☐ Tranxene
- ☐ Triazolam
- ☐ Xanax
- ☐ Xanax XR

☐ Other (specify):

Strength: Dosage Instructions: Quantity: Days Supply:

Diagnosis:

- ☐ Generalized anxiety disorder
- ☐ Panic attack with or without agoraphobia
- ☐ Seizure
- ☐ Non-progressive motor disorder
- ☐ Dystonia
- ☐ Other (please specify)

Trial 1 with preferred agent:

Drug Name: Strength:

Dosage instructions: Trial Date from: Trial Date to:

Trial 2 with preferred agent:

Drug Name: Strength:

Dosage instructions: Trial Date from: Trial Date to:

Medical or contraindication reason to override trial requirements:

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.