AmeriHealth Caritas Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization
Chronic Pain Syndromes

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 pregabalin (Lyrica®) and milnacipran (Savella™). These drugs will be considered for their FDA indication(s) and other conditions as listed in the compendia. Requests for doses above the manufacturer recommended dose will not be considered. The trial examples below are not an all inclusive list. Please refer to the Preferred Drug List (PDL) located at www.iowamedicaidpdl.com for a complete list of preferred drugs in these therapeutic classes. For patients with a chronic pain diagnosis who are currently taking opioids, as seen in pharmacy claims, a plan to decrease and/or discontinue the opioid(s) must be provided with the initial request. Initial authorization will be given for three (3) months. There must be a significant decrease in opioid use or discontinuation of opioid(s) after the initial three (3) month authorization for further approval consideration. Additional prior authorizations will be considered with documentation of a continued decrease in opioid utilization. Requests for non-preferred brand drugs, when there is a preferred A-rated bioequivalent generic product available, are also subject to the Selected Brand Name prior authorization criteria and must be included with this request. Payment will be considered under the following conditions:

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

Preferred (no PA required within quantity limit): ☐ Duloxetine Non-Preferred: ☐ Cymbalta ☐ Lyrica ☐ Savella

Strength: Dosage Instructions: Quantity: Days Supply:

☐ Fibromyalgia (Lyrica® or Savella™)

A diagnosis of fibromyalgia with the following documented trials:

a) A trial and therapy failure at a therapeutic dose with gabapentin plus one of the following preferred generic agents: tricyclic antidepressant (amitriptyline, nortriptyline) or SNRI (duloxetine, venlafaxine er).

Gabapentin Trial

Dose: Trial Dates: Failure Reason:

Preferred Drug Trial #2

Drug Name & Dose: Trial Dates: Failure Reason:

b) Documented non-pharmacologic therapies (such as cognitive behavior therapies, exercise, etc.)

Non-Pharmacological Treatments Tried:

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☐ Post-Herpetic Neuralgia (Lyrica®)

A diagnosis of post-herpetic neuralgia with the following documented trials: A trial and therapy failure at a therapeutic dose with gabapentin plus one of the following: tricyclic antidepressant (amitriptyline, nortriptyline), topical lidocaine, or valproate.

Gabapentin Trial

Dose: Trial Dates: Failure Reason:

Preferred Drug Trial #2

Drug Name & Dose: Trial Dates: Failure Reason:

☐ Diabetic Peripheral Neuropathy (duloxetine or Lyrica®)

A diagnosis of diabetic peripheral neuropathy with the following documented trials: A trial and therapy failure at a therapeutic dose with gabapentin plus one of the following: tricyclic antidepressant (amitriptyline, nortriptyline), duloxetine or topical lidocaine.

Gabapentin Trial

Dose: Trial Dates: Failure Reason:

Preferred Drug Trial #2

Drug Name & Dose: Trial Dates: Failure Reason:

☐ Partial Onset Seizures, as adjunct therapy (Lyrica®):

☐ Other Diagnosis of Use:

Must complete for chronic pain diagnosis:

Does the member have current opioid use: ☐ Yes Name/Dose: ☐ No

If yes, provide specific plan, including time line, to decrease and/or discontinue opioid use:

Other relevant information:

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 acknowledge 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.