AmeriHealth Caritas Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization
Extended Release Formulations

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:

Payment for a non-preferred extended release formulation will be considered when the following criteria for coverage are met: 1) Previous trial and therapy failure with the preferred immediate release product of the same chemical entity at a therapeutic dose that resulted in a partial response with a documented intolerance and 2) Previous trial and therapy failure at a therapeutic dose with a preferred drug of a different chemical entity indicated to treat the submitted diagnosis. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Prior authorization is required for the following extended release formulations: Adoxa , Amoxicillin ER, Amrix, Astagraf XL, Augmentin XR, Cardura XL, Cipro XR, ConZip ER, Coreg CR, Doryx, Envarsus XR, Flagyl ER, Fortamet, Gralise, Keppra XR, Lamictal XR, Luvox CR, metronidazole sr, Mirapex ER, Moxatag, Namenda XR, Oleptro, Oxtellar XR, Pramipexole ER, Prozac Weekly, Qudexy XR, Quetiapine ER, Rayos, Requip XL, Rythmol SR, Ryzolt, Seroquel XR, Sitavig, Solodyn ER, topiramate er, tramadol sr, Trokendi XR, Ultram ER.

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

Drug name: Strength:

Dosage instructions: Quantity: Days supply:

Diagnosis:

Previous therapy with immediate release product of same chemical entity (include strength, exact date ranges, and reason for failure):

Previous therapy with a preferred drug of a different chemical entity (include strength, exact date ranges, and reason for failure):

Contraindication(s) to using immediate release product and/or a preferred drug of a different chemical entity:

Possible drug interactions/conflicting drug therapies:

AmeriHealth Caritas Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization
Extended Release Formulations

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.