AmeriHealth Caritas Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization
Narcan Nasal Spray

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 a patient requiring more than two doses of Narcan (naloxone) nasal spray per 365 days. Requests for quantities greater than two doses per 365 days will be considered under the following conditions: 1) Documentation is provided indicating why patient needs additional doses of Narcan (naloxone) nasal spray (accidental overdose, intentional overdose, other reason); and 2) Narcan (naloxone) nasal spray is to be used solely for the patient it is prescribed for; and 3) The patient is receiving an opioid as verified in pharmacy claims; and 4) Patient has been reeducated on opioid overdose prevention; and 5) Documentation is provided on the steps taken to decrease the chance of opioid overdose again; and 6) A treatment plan is included documenting a plan to lower the opioid dose.

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

Preferred

☐ Narcan

Dosing instructions: _____ Quantity: _____ Days supply:_____

Most recent fill date: _____ Most recent date medication used: _____

Medical necessity for exceeding quantity limit:

☐ Intentional overdose ☐ Accidental overdose ☐ Other reason: _____

Will Narcan be used solely for the patient it is prescribed for? ☐ Yes ☐ No

Is patient currently receiving an opioid as verified in pharmacy claims?

☐ No ☐ Yes, provide drug name and most current fill date: _____

Has patient been reeducated on opioid overdose prevention? ☐ No ☐ Yes, date provided:_____

Provide documentation on the steps taken to decrease the chance of opioid overdose again:

Provide treatment plan to lower opioid dose:

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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 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 that the member continues to be eligible for Medicaid by inspection of the member's Medicaid eligibility card and/or contacting the county Department of Human Services.

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