AmeriHealth Caritas
Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization
Nonparenteral Vasopressin Derivatives of Posterior Pituitary Hormone Products

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-parenteral vasopressin derivatives of posterior pituitary hormone products. Payment for preferred non-parenteral vasopressin derivatives of posterior pituitary hormone products will be authorized for the following diagnoses: 1. Diabetes Insipidus, 2. Hemophilia A, and 3. Von Willebrand's disease.

Requests for desmopressin nasal spray for the treatment of nocturnal enuresis will not be considered. Payment for non-preferred non-parenteral vasopressin derivatives will be authorized only for cases in which there is documentation of trial(s) and therapy failure with the preferred agent(s). Please refer to the Selected Brand-Name Drugs prior authorization form if requesting a non-preferred brand-name product.

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

Preferred	Non-Preferred
☐ Desmopressin Nasal Solution	☐ DDDAVP Acetate Nasal Solution
☐ Desmopressin Nasal Spray	☐ DDAVP Acetate Nasal Spray
☐ Desmopressin Tablets	☐ DDAVP Tablets
☐ Stimate Nasal Spray	

Strength: Dosage Instructions: Quantity: Days Supply:

Diagnosis:

☐ Diabetes insipidus
☐ Von Willebrand's disease
☐ Nocturnal enuresis
*If nocturnal enuresis, is patient 6 years old or older?
☐ Yes ☐ No

☐ Hemophilia A
☐ Other (please specify)

Please specify exact date range of last drug-free interval: From: To:

Previous therapy (include drug name(s), strength and exact date ranges):

Reason for use of Non-Preferred drug requiring prior approval:

Please print – accuracy is important.

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.