AmeriHealth Caritas Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization

Selected Brand Name Drugs
AmeriHealth Caritas Iowa MedWatch Form

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 selected brand-name drugs, as determined by the Department, for which there is available an "A" rated bioequivalent generic product as determined by the Federal Food and Drug Administration, unless the brand drug has been designated by the Department as preferred (payable) under the Iowa Medicaid Preferred Drug List (PDL). For prior authorization to be considered, the prescriber must submit a completed Selected Brand-Name Drugs PA form and AmeriHealth Caritas Iowa MedWatch form with:

1. Documentation of trials and therapy failures with two different generic manufacturers of the same chemical entity. If an allergy to an inactive component is suspected, the second trial must be with a generic product that does not contain the allergen, if available.
2. Documentation of the failure must include the specific adverse reaction as defined by the FDA (See Section B of the MedWatch form). Intolerances, such as nausea or vomiting, to the generic drug will not be considered as a basis for approval.

Trials may be overridden when evidence is provided that use of the generic product would be medically contraindicated.

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 (include drug name(s), manufacturer/labeler, strength, exact date ranges, and specific failure reason):* To be documented on MedWatch form

Other relevant information:

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Revised for submission of brand medically necessary requests for AmeriHealth Caritas Iowa Pharmacy Program. Prescriber must have witnessed or has documentation that the manifestation of adverse event(s) is linked to generic drug. Completion of form does not automatically grant approval; incomplete forms will be returned with denial.***

A. Patient Information

Name:			☐ Male ☐ Female
AmeriHealth Caritas Iowa ID:		DOB:	Weight: lbs.
Phone:	Has a generic been tried before? ☐ Yes ☐ No	Give date:	Age at time of event:

B. Adverse Event Or Contraindication

1. ☐ Adverse Reaction/Treatment Failure and/or ☐ Contraindication

2. Outcomes Attributed to Adverse Event: (Check all that apply.)
   ☐ Death: _____(mo/day/yr) ☐ Disability ☐ Life-threatening ☐ Congenital Anomaly
   ☐ Required Intervention to Prevent Permanent Impairment/Damage ☐ Hospitalization – Initial or Prolonged

3. Date of Event (mo/day/yr):	4. Date of This Report (mo/day/yr):

5. Describe Event or Problem; Relevant History and Tests:

C. Suspect Medications

1. Name (Give labeled strength and mfr/labeler, if known):	#1:	#2:
2. Dose, Frequency and Route Used	#1:	#2:
3. Therapy Dates:	#1:	#2:
4. Diagnosis for Use (Indication):	#1:	#2:
5. Event Abated After Use Stopped or Dose Reduced?	#1: ☐ Yes ☐ No ☐ N/A	#2: ☐ Yes ☐ No ☐ N/A
6. Lot # (if known):	#1:	#2:
7. Event Reappeared After Reintroduction:	#1: ☐ Yes ☐ No ☐ N/A	#2: ☐ Yes ☐ No ☐ N/A

8. NDC # (specify generic manufacturer):

D. Degree Of Certainty That The Adverse Drug Reaction Is Due To Generic

☐ **Definite.** The reaction follows a reasonable temporal sequence after generic drug exposure or a toxic blood level of the generic drug has been established in body fluids or tissue. The reaction follows a recognized response to the suspected generic drug. The reaction is confirmed by improvement on withdrawing the generic drug and reappears on re-exposure. "Other than drug causes" such as other drugs or toxins or concomitant disease states that can cause similar clinical reactions are ruled out.

☐ **Probable.** The reaction follows a reasonable temporal sequence after generic drug exposure. The reaction follows a recognized response to the suspected generic drug. The reaction is confirmed by withdrawal but not by exposure to the generic drug. The reaction cannot be reasonably explained by known characteristics of the recipient's clinical state.

☐ **Possible.** The reaction follows a temporal sequence after generic drug exposure. The reaction follows a possible recognized pattern to the suspected generic drug. The reaction could be explained by the recipient's clinical state (i.e. other than the suspected generic drug).

☐ **Doubtful.** The reaction is likely to be related to factors other than the suspected generic drug.

☐ **Negative.** The findings clearly eliminate the possibility of a drug reaction caused by the generic version of the drug.

List concomitant medications being taken by patient:

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E. Reporter Certification	
Signature certifies that brand is medically necessary Prescriber's Name:	
Signature:	NPI#:
Address:	
Phone:	Fax:
Did the prescriber witness the ADR? ☐ Yes ☐ No	Has the ADR been previously reported to the FDA? ☐ Yes ☐ No

Please fax form to the AmeriHealth Caritas Iowa Pharmacy Program at **1-855-825-2714**. **Do not** fax directly to the FDA.

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.