

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-preferred antidepressants subject to clinical criteria. Requests for doses above the manufacturer recommended dose will not be considered. Payment will be considered for patients when the following criteria are met: 1) The patient has a diagnosis of Major Depressive Disorder (MDD) and is 18 years of age or older; and 2) Documentation of a previous trial and therapy failure at a therapeutic dose with two preferred generic SSRIs; and 3) Documentation of a previous trial and therapy failure at a therapeutic dose with one preferred generic SNRI; and 4) Documentation of a previous trial and therapy failure at a therapeutic dose with one non-SSRI/SNRI generic antidepressant. 5) If the request is for an isomer, prodrug or metabolite of a medication indicated for MDD, one of the trials must be with the preferred parent drug of the same chemical entity that resulted in a partial response with a documented intolerance. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

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

Non-Preferred

- | | | | |
|-----------------------------------|-------------------------------------|----------------------------------|-----------------------------------|
| <input type="checkbox"/> Aplenzin | <input type="checkbox"/> Brintellix | <input type="checkbox"/> Fetzima | <input type="checkbox"/> Khedezla |
| <input type="checkbox"/> Pristiq | <input type="checkbox"/> Viibryd | | |

Strength: Dosage Instructions: Quantity: Days Supply:

Diagnosis:

Preferred Generic SSRI Trial 1:		
Drug Name & Dose:	Trial Dates:	Failure Reason:
Preferred Generic SSRI Trial 2:		
Drug Name & Dose:	Trial Dates:	Failure Reason:
Preferred Generic SNRI Trial:		
Drug Name & Dose:	Trial Dates:	Failure Reason:
Preferred Non-SSRI/SNRI Generic Antidepressant Trial:		
Drug Name & Dose:	Trial Dates:	Failure Reason:

Medical or contraindication reason to override trial requirements:

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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 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.