AmeriHealth Caritas Iowa

# AmeriHealth Caritas Iowa
# Request for Prior Authorization

## Concurrent IM/PO Antipsychotic Utilization

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: |

A prior authorization is required for concurrent long acting injectable and oral antipsychotic medications after 12 weeks (84 days) of concomitant treatment for members 18 years of age and older. Consideration of concomitant therapy beyond 12 weeks (84 days) will require documentation of medical necessity. Prior authorization is required for all non-preferred antipsychotics as indicated on the Iowa Medicaid Preferred Drug List beginning the first day of therapy. Payment for non-preferred antipsychotics will be considered only for cases in which there is documentation of previous trials and therapy failures with a preferred agent.

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

## Injectable Antipsychotic Medication:

Dosing instructions:

Drug name and strength: Quantity: Days supply:

## Oral Antipsychotic Medication:

Dosing instructions:

Drug name and strength: Quantity: Days supply:

Diagnosis:

Medical necessity for concurrent IM/PO antipsychotic use beyond 12 weeks (84 days):

Proposed drug tapering schedule:

Reason for use of non-preferred drug requiring prior approval:

Other medical conditions to consider:

AmeriHealth Caritas Iowa

# AmeriHealth Caritas Iowa
# Request for Prior Authorization
## Concurrent IM/PO Antipsychotic Utilization

**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:<br>(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.