AmeriHealth Caritas
Iowa

AmeriHealth Caritas Iowa
Request for Fifteen Day Initial Prescription Supply Override

This form is used for both preferred and non-preferred agents.

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:

Designated drugs are limited to a fifteen day initial supply. These drugs have been identified with high side effect profiles, high discontinuation rates, or frequent dose adjustments. The initial prescription supply limit ensures cost effectiveness without waste of unused medications. These drugs are identified on the Fifteen Day Initial Prescription Supply Limit list located on the website **www.iowamedicaidpdl.com** under the Preferred Drug Lists tab. Documentation of medical necessity, excluding patient convenience, is required for consideration of the fifteen day initial supply override.

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

Drug Name: Strength:

Dosing Instructions: Quantity:

Diagnosis:

Medical Necessity Documentation:

Please note: reasons other than patient convenience are required.

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.