AmeriHealth Caritas Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization
Insulin, Pre-filled Pens

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 pre-filled insulin pens. For pre-filled insulin pens where the requested insulin is available in a vial, payment will be considered for a diagnosis of diabetes mellitus and FDA approved age in addition to the following criteria:
1) The patient's visual or motor skills are impaired to such that they cannot accurately draw up their own insulin (not applicable for pediatric patients), and 2) There is no caregiver available to provide assistance, and 3) Patient does not reside in a long-term care facility, and 4) For requests for non-preferred pre-filled pens, patient has documentation of a previous trial and therapy failure with a preferred pre-filled insulin pen within the same class (i.e. rapid, regular, or basal).

For pre-filled insulin pens where the requested insulin is not available in a vial, payment will be considered for a diagnosis of diabetes mellitus and FDA approved age in addition to the following criteria:
1) Preferred pre-filled insulin pens: Patient has documentation of a previous trial and therapy failure with a preferred insulin agent within the same class (i.e. rapid, regular, or basal) or clinical rationale as to why the patient cannot use a preferred insulin agent, and 2) Non-preferred pre-filled insulin pens: Patient has documentation of a previous trial and therapy failure with a preferred insulin agent within the same class (i.e. rapid, regular, or basal) and 3) Requests for Toujeo will require clinical rationale as to why the patient cannot use Lantus and patient must be using a minimum of 100 units of Lantus per day.

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

Preferred:

☐ NovoLog FlexPen
☐ NovoLog Mix 70/30 Cartridge
☐ NovoLog Mix 70/30
☐ NovoLog PenFill

Non-Preferred:

☐ Apidra SoloSTAR
☐ Humalog KWP
☐ Humalog Mix 75/25 Pen
☐ Humalog Mix 50/50 Pen
☐ Humulin N Pen
☐ Humulin R Pen
☐ Humulin 70/30 Pen

Non-Preferred:
(not available in vial)

☐ Basaglar KwikPen
☐ Toujeo SoloStar
☐ Tresiba FlexTouch

Number of units: How often:

Number of cartridges/pens/penfills (circle requested item)

Diagnosis:

☐ Requests for insulin agents available in a vial:

What visual or physical conditions limit the patient's ability to prepare their own syringes (not applicable for pediatric patients)?

Does the patient lack capable assistance residing with them? ☐Yes ☐No

Does the patient reside in a long-term care facility? ☐Yes ☐No

AmeriHealth Caritas
Iowa

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Request for a non-preferred pre-filled insulin pen, document preferred pre-filled insulin pen trial within the same class:

Drug name: Dosage instructions:

Trial start date: Trial end date:

Failure reasons:

☐ Requests for insulin agents not available in a vial:

Document preferred insulin trial in same class as requested agent:

Drug name: Dosage instructions:

Trial start date: Trial end date:

Failure reasons:

Toujeo:

Patient's current daily Lantus dose:

Clinical rationale as to why
patient cannot use Lantus:

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.