AmeriHealth Caritas Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization
Methotrexate Injection

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 non-preferred methotrexate injection. Payment will be considered under the following conditions: Patient's visual or motor skills are impaired to such that they cannot accurately draw up their own preferred generic methotrexate injection and there is no caregiver available to provide assistance in addition to: 1) Diagnosis of severe, active rheumatoid arthritis or polyarticular juvenile idiopathic arthritis and ALL of the following: a) Prescribed by a rheumatologist; and b) Patient has documented trial and intolerance with oral methotrexate; and c) Patient has documented trial and therapy failure or intolerance with at least one other non-biologic DMARD; or 2) Diagnosis of severe, recalcitrant, disabling psoriasis and ALL of the following: a) Patient is 18 years of age or older; and b) Prescribed by a dermatologist; and c) Patient has documentation of an inadequate response to all other standard therapies (oral methotrexate, topical corticosteroids, vitamin D analogues, cyclosporine, systemic retinoids, tazarotene, and phototherapy). The required trials may be overridden when documented evidence is provided that use of these agents would be medially contraindicated.

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

Non-Preferred: ☐ Otrexup ☐ Rasuvo

Dosage Instructions:

Strength: Quantity: Days Supply:

Diagnosis (additional criteria below):

Limitations to use of a preferred generic methotrexate injection:

What visual or physical conditions limit the patient's ability to prepare their own injections?

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

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

☐ **Severe, active rheumatoid arthritis (RA) or polyarticular juvenile idiopathic arthritis (pJIA):**

Prescriber Specialty: ☐ Rheumatologist ☐ Other

Intolerance with oral methotrexate:

Dose: Trial dates:

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Specific Intolerance:

Treatment failure with one other non-biologic DMARD (hydroxychloroquine, leflunomide, minocycline or sulfasalazine):

Drug name and dose: Trial dates:

Reason for failure:

☐ **Severe, recalcitrant disabling psoriasis (Patient must be 18 years of age or older):**

Prescriber Specialty: ☐ Dermatologist ☐ Other

Treatment failure with all standard therapies (include trial dates, dose & failure reason for each):

☐ Oral methotrexate:

☐ Topical corticosteroids:

☐ Vitamin D analogues:

☐ Cyclosporine:

☐ Systemic retinoids:

☐ Tazarotene:

☐ Phototherapy:

Possible drug interactions/conflicting drug therapies:

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: (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.