AmeriHealth Caritas Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization
Muscle Relaxants

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.

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

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 muscle relaxants. Payment for non-preferred muscle relaxants is authorized only for cases where there is documentation of previous trials and therapy failures with at least three preferred muscle relaxants. Requests for carisoprodol will be approved for a maximum of 120 tablets per 180 days at a maximum dose of 4 tablets per day when the criteria for coverage are met. ˣIf a non-preferred long-acting medication is requested, one trial must include the preferred immediate release product of the same chemical entity at a therapeutic dose, unless evidence is provided that use of these products would be medically contraindicated.

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

Preferred

- ☐ Baclofen
- ☐ Chlorzoxazone
- ☐ Cyclobenzaprine
- ☐ Lioresal Intrathecal
- ☐ Methocarbamol
- ☐ Orphenadrine ER/CR
- ☐ Orphenadrine/ASA/Caffeine 25/385/30
- ☐ Tizanidine

Non-Preferred

- ☐ Amrixˣ
- ☐ Carisoprodol
- ☐ Carisoprodol/ASA
- ☐ Carisoprodol/ASA/Codeine
- ☐ Cyclobenzaprine ERˣ
- ☐ Dantrium
- ☐ Orphenadrine Compound DS
- ☐ Other (specify) _____
- ☐ Norflex
- ☐ Orphenadrine
- ☐ Orphengesic Forte
- ☐ Skelaxin
- ☐ Soma
- ☐ Zanaflex

Dosage Instructions:

Strength: Quantity: Days Supply:

Diagnosis:

Preferred Trial 1

Drug Name: Strength:

Dosage Instructions:

Trial date from: Trial date to:

Specify failure:

AmeriHealth Caritas Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization
Muscle Relaxants

Form applies to IA Health Link and ***hawk-i*** plans.

Please print – accuracy is important.

Preferred Trial 2

Drug Name: Strength:

Dosage Instructions:

Trial date from: Trial date to:

Specify failure:

Preferred Trial 3

Drug Name: Strength:

Dosage Instructions:

Trial date from: Trial date to:

Specify failure:

Reason for use of Non-Preferred drug requiring prior approval: _____

Other medical conditions to consider: _____

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.