

**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:
<b>Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.</b>			
Pharmacy NPI:		Pharmacy fax:	NDC:

Prior authorization is required for narcotic agonist-antagonist nasal sprays. For consideration, the diagnosis must be supplied. If the use is for the treatment of migraine headaches, documentation of current prophylactic therapy or documentation of previous trials and therapy failures with two different prophylactic medications must be provided. There must also be documented treatment failure or contraindication to triptans for the acute treatment of migraines. For other pain conditions, there must be documentation of treatment failure or contraindication to oral administration. Payment for non-preferred narcotic agonist-antagonist nasal sprays will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. Quantities are limited to 2 bottles or 5 milliliters per 30 days. Payment for narcotic agonist-antagonist nasal sprays beyond this limit will be considered on an individual basis after review of submitted documentation.

Please note: AmeriHealth Caritas Iowa uses Iowa Medicaid Enterprise criteria. For complete criteria, please consult [www.iowamedicaidpdl.com/pa\\_criteria](http://www.iowamedicaidpdl.com/pa_criteria).

Preferred:  Butorphanol Tartrate Nasal Spray

Dosage Instructions:

Strength: \_\_\_\_\_ Quantity: \_\_\_\_\_ Days Supply: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

**If migraine, please document current prophylactic therapy:**

Drug Name: \_\_\_\_\_ Strength: \_\_\_\_\_

Dosage Instructions: \_\_\_\_\_

**If not currently using prophylactic therapy, please document 2 previous trials:**

**Trial 1 with prophylactic treatment:**

Drug Name: \_\_\_\_\_ Strength: \_\_\_\_\_

Dosage Instructions: \_\_\_\_\_

Trial Date from: \_\_\_\_\_ Trial Date to: \_\_\_\_\_

Failure documentation: \_\_\_\_\_

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**Trial 2 with prophylactic treatment:**

Drug Name: \_\_\_\_\_ Strength: \_\_\_\_\_

Dosage Instructions: \_\_\_\_\_

Trial Date from: \_\_\_\_\_ Trial Date to: \_\_\_\_\_

Failure documentation: \_\_\_\_\_

Medical or contraindication reason to override trial requirements: \_\_\_\_\_

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

**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](http://www.amerihealthcaritasia.com/Provider) to confirm your version of this form.