AmeriHealth Caritas Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization
New-to-Market Drugs

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 new-to-market drugs not yet reviewed by the Iowa Medicaid Pharmaceutical & Therapeutics (P&T) Committee. Payment will be considered for patients when the following criteria are met:

1. Patient has an FDA approved or compendia indication for the requested drug; and
2. If the requested drug falls in a therapeutic category/class with existing prior authorization criteria, the requested drug must meet the criteria for the same indication; or
3. If no clinical criteria are established for the requested drug, patient has tried and failed at least two preferred drugs, when available, from the Iowa Medicaid Preferred Drug List (PDL) for the submitted indication; and
4. Request must adhere to all FDA approved labeling.

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated..

Once new-to-market drugs are reviewed by the P&T Committee, they will be placed on the PDL which will dictate ongoing PA criteria, if applicable.

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

Drug name:

Strength: Dosage instructions: Quantity: Days supply:

Diagnosis:

Preferred drug trial 1:

Drug name/dose: Trial dates:

Failure reason:

Preferred drug trial 2:

Drug name/dose: Trial dates:

Failure reason:

Pertinent lab data:

Other medical conditions to consider:

Other relevant information:

Possible drug interactions/conflicting drug therapies:

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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.