AmeriHealth Caritas Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization
Nonsteroidal Anti-Inflammatory 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 all non-preferred nonsteroidal anti-inflammatory drugs (nsaids) and COX-2 inhibitors. Prior authorization is not required for preferred nsaids or COX-2 inhibitors. 1. Requests for a non-preferred nsaid must document previous trials and therapy failures with at least three preferred nsaids. 2. Requests for a non-preferred COX-2 inhibitor must document previous trials and therapy failures with three preferred nsaids, two of which must be preferred COX-2 preferentially selective nsaids. 3) Requests for a non-preferred topical nsaid must document previous trials and therapy failures with three preferred nsaids. The trials must include two preferred COX-2 preferentially selective nsaids and the oral drug of the same chemical entity. In addition, the use of a topical delivery system must be deemed medically necessary. 4) Requests for a non-preferred extended release nsaid must document previous trials and therapy failures with three preferred nsaids, one of which must be the preferred immediate release nsaid of the same chemical entity at a therapeutic dose that resulted in a partial response with a documented intolerance. The required trials may be overridden when documented evidence is provided that use of these agents 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 (No PA required)

Diclofenac Sod./Pot.
Diclofenac Sod. EC/DR
Etodolac 400mg/500mg
Flurbiprofen
Ibuprofen
Ibuprofen Susp.
Indomethacin
Ketoprofen
Meloxicam (COX-2)
Nabumetone (COX-2)
Naprosyn Susp.
Naproxen
Naproxen EC/ER
Naproxen Sodium 550mg
Salsalate
Sulindac

Non-Preferred (PA required for all products)

☐ Arthrotec
☐ Celebrex
☐ Celecoxib
☐ Diclofenac ER/XR*
☐ EC-Naprosyn
☐ Etodollac CR/ER/XR
☐ Fenoprofen
☐ Flector Patch
☐ Indomethacin ER*
☐ Ketoprofen ER
☐ Meclofenamate Sod
☐ Naprelan
☐ Oxaprosin
☐ Pennsaid
☐ Piroxicam
☐ Ponstel
☐ Tivorbex
☐ Tolmetin Sod
☐ Vivlodex
☐ Voltaren Gel
☐ Voltaren XR
☐ Zipsor
☐ Zorvolex
☐ Other (specify): _____

Strength: Dosage Instructions:

Quantity: Days Supply:

Diagnosis:

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Preferred Drug Trial 1

Drug Name & Dose: Trial Dates: Failure Reason:

Preferred Drug Trial 2

Drug Name & Dose: Trial Dates: Failure Reason:

Preferred Drug Trial 3

Drug Name & Dose: Trial Dates: Failure Reason:

Medical Necessity for alternative delivery system:

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 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.