AmeriHealth Caritas
Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization

Serotonin 5-HT1 Receptor Agonists

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 preferred serotonin 5-HT1-receptor agonists for quantities exceeding 12 unit doses of tablets, syringes or sprays per 30 days. Payment for serotonin 5-HT1-receptor agonists beyond this limit will be considered on an individual basis after review of submitted documentation. Prior authorization will be required for all non-preferred serotonin 5-HT1-receptor agonists as indicated on the Iowa Medicaid Preferred Drug List beginning the first day of therapy. Payment for non-preferred serotonin 5-HT1-receptor agonists will be authorized only for cases in which there is documentation of previous trials and therapy failures with two preferred agents.

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

Preferred (PA required after 12 doses in 30 days)	Non-Preferred (PA required from Day 1)		
☐ Imitrex injectable	☐ Almotriptan	☐ Maxalt	☐ Treximet*
☐ Naratriptan	☐ Amerge	☐ Maxalt MLT	☐ Zecuity
☐ Rizatriptan ODT	☐ Axert	☐ Onzentra Xsail	☐ Zembrace
☐ Rizatriptan tablets	☐ Frova	☐ Relpax	☐ Zolmitriptan
☐ Sumatriptan NS	☐ Frovatriptan	☐ Sumatriptan Inj	☐ Zomig
☐ Sumatriptan tablets	☐ Imitrex nasal spray	☐ Sumavel DosePro	☐ Zomig ZMT
	☐ Imitrex tabs		

Strength: Dosage instructions: Quantity: Days supply:

Diagnosis:

If migraine, please document the current prophylactic therapy or two previous trials and therapy failures with two different prophylactic medications including drug names, strength, exact date ranges, and failure reasons:

Medical or contraindication reason to override trial requirements:

Previous migraine therapy (include drug/dose/duration):

Reason for use of non-preferred drug requiring prior approval:

Other medical conditions to consider:

* Requests for non-preferred combination products may only be considered after documented separate trials and therapy failures with the individual ingredients. For consideration, the following information must be supplied: 1. The diagnosis requiring therapy. 2. Documentation of current prophylactic therapy or documentation of previous trials and therapy failures with two different prophylactic medications.

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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.