## Iowa Department of Human Services REQUEST FOR PRIOR AUTHORIZATION NON-PREFERRED DRUG

(PLEASE PRINT - ACCURACY IS IMPORTANT)

IA Medicaid Member ID #:     P	atient Name:	DOB:
Patient Address:		
Provider NPI:   _ _ _	Prescriber Name:	Phone:
Prescriber Address:		Fax:
Pharmacy Name: Add Prescriber must fill all information above. It Pharmacy		
NPI:   _  Pharmac	y Fax:	NDC :   _
List. Payment for a non-preferred medica	ation will be authorize apy failure with the prelly contraindicated. * 1	referred agent, unless evidence is provided Please refer to the Selected Brand-Name
Drug Name:	Strength:	
Dosage Instructions:	Quantity:	Days Supply:
Diagnosis:		
Previous therapy (include drug name(s), stre	ength and exact date rai	nges):
Reason for use of Non-Preferred drug requi	ring prior approval:	
Pertinent Lab data:		
Other medical conditions to consider:		
Other relevant information:		
Possible drug interactions/conflicting drug t	therapies:	
Attach lab results and other documentation	n as necessary.	
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.