



Iowa Department of Human Services
Request for Prior Authorization
SELECTED BRAND NAME DRUGS
Iowa Medicaid MedWatch Form

FAX Completed Form To
 1 (800) 574-2515
Provider Help Desk
 1 (877) 776-1567

Revised for submission of brand medically necessary requests for Iowa Pharmacy Program. Prescriber must have witnessed or has documentation that the manifestation of adverse event(s) is linked to generic drug. Completion of form does not automatically grant approval; incomplete forms will be returned with denial.***

A. PATIENT INFORMATION

Name: _____ Sex: F M
 Medicaid ID: _____ DOB: ____/____/____
 Weight: _____ lbs Phone: (____) _____
 Has a generic been tried before? Yes No
 Give date: ____/____/____ Age at time of event: _____

B. ADVERSE EVENT OR CONTRAINDICATION

1. Adverse Reaction/Treatment Failure and/or Contraindication

2. Outcomes Attributed to Adverse Event: (Check all that apply.)
 Death: _____ (month/day/year)
 Disability
 Life-threatening
 Congenital Anomaly
 Required Intervention to Prevent Permanent Impairment/Damage
 Hospitalization – Initial or Prolonged

3. Date of Event (mo/day/yr) _____ 4. Date of This Report (mo/day/yr) _____

5. Describe Event or Problem; Relevant History & Tests

C. SUSPECT MEDICATIONS

1. Name (Give labeled strength & mfr/labeler, if known)
 #1 _____
 #2 _____

2. Dose, Frequency & Route Used
 #1 _____
 #2 _____

3. Therapy Dates
 #1 _____
 #2 _____

4. Diagnosis for Use (Indication)
 #1 _____
 #2 _____

5. Event Abated After Use Stopped or Dose Reduced?
 #1 Yes No N/A
 #2 Yes No N/A

6. Lot # (if known)
 #1 _____
 #2 _____

8. Event Reappeared After Reintroduction
 #1 Yes No N/A
 #2 Yes No N/A

9. NDC # (specify generic manufacturer)
 #1 _____
 #2 _____

D. DEGREE OF CERTAINTY THAT THE ADVERSE DRUG REACTION IS DUE TO GENERIC

___ **Definite.** The reaction follows a reasonable temporal sequence after generic drug exposure or a toxic blood level of the generic drug has been established in body fluids or tissue. The reaction follows a recognized response to the suspected generic drug. The reaction is confirmed by improvement on withdrawing the generic drug and reappears on re-exposure. "Other than drug causes" such as other drugs or toxins or concomitant disease states that can cause similar clinical reactions are ruled out.

___ **Probable.** The reaction follows a reasonable temporal sequence after generic drug exposure. The reaction follows a recognized response to the suspected generic drug. The reaction is confirmed by withdrawal but not by exposure to the generic drug. The reaction cannot be reasonably explained by known characteristics of the recipient's clinical state.

___ **Possible.** The reaction follows a temporal sequence after generic drug exposure. The reaction follows a possible recognized pattern to the suspected generic drug. The reaction could be explained by the recipient's clinical state (i.e. other than the suspected generic drug).

___ **Doubtful.** The reaction is likely to be related to factors other than the suspected generic drug.

___ **Negative.** The findings clearly eliminate the possibility of a drug reaction caused by the generic version of the drug.

List concomitant medications being taken by patient.

E. REPORTER CERTIFICATION

Signature certifies that brand is medically necessary

Prescriber's Name _____
 Signature _____ NPI # _____
 Address: _____

 Phone #: (____) _____ - _____
 Fax #: (____) _____ - _____

Did the prescriber witness the ADR? Yes No
 Has the ADR been previously reported to the FDA? Yes No

Please FAX form to the Iowa Medicaid Pharmacy Program at 1-800-574-2515 DO NOT fax directly to the FDA