Provider Help Desk
1 (877) 776 –1567

FAX Completed Form To
1 (800) 574-2515

Iowa Department of Human Services
REQUEST FOR PRIOR AUTHORIZATION
Concurrent IM/PO Antipsychotic Utilization

This form is used for both preferred and non-preferred agents.

(PLEASE PRINT - ACCURACY IS IMPORTANT)

IA Medicaid
Member ID #: |___|___|___|___|___|___|___|___|___| Patient Name: _____ DOB: _____

Patient Address:_____

Provider NPI: |___|___|___|___|___|___|___|___|___|___| Prescriber Name:_____ Phone:_____

Prescriber Address:_____ Fax:_____

Pharmacy Name:_____ Address:_____ Phone:_____

Prescriber must fill all information above. It must be legible, correct and complete or form will be returned.

Pharmacy

NPI: |___|___|___|___|___|___|___|___|___|___| Pharmacy Fax: _____ NDC : |___|___|___|___|___|___|___|___|___|___|___|

A prior authorization is required for concurrent long acting injectable and oral antipsychotic medications after 12 weeks (84 days) of concomitant treatment. Consideration of concomitant therapy beyond 12 weeks (84 days) will require documentation of medical necessity. Prior authorization is required for all non-preferred antipsychotics as indicated on the Iowa Medicaid Preferred Drug List beginning the first day of therapy. Payment for non-preferred antipsychotics will be considered only for cases in which there is documentation of previous trials and therapy failures with a preferred agent.

Injectable Antipsychotic Medication:

Drug Name & Strength: _____Dosing Instructions: _____ Quantity: _____Days supply: _____

Oral Antipsychotic Medication:

Drug Name & Strength: _____Dosing Instructions: _____ Quantity: _____Days supply: _____

Diagnosis: _____

Medical Necessity for concurrent IM/PO antipsychotic use beyond 12 weeks (84 days): _____

_____

_____

Proposed Drug Tapering Schedule: _____

_____

Reason for use of Non-Preferred drug requiring prior approval: _____

_____

Other medical conditions to consider: _____

Attach lab results and other documentation as necessary.

Prescriber Signature: _____ Date of Submission: _____
***MUST MATCH PRESCRIBER LISTED ABOVE**

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.