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

Iowa Department of Human Services REQUEST FOR PRIOR AUTHORIZATION MISCELLANEOUS ONE Drug per Form ONLY

(PLEASE PRINT - ACCURACY IS IMPORTANT)

IA Medicaid Member ID #: Patient Name: _	DOB:
Patient Address:	
Provider ID/NPI: Prescribe	r 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 NABP or	
NPI: _ Pharmacy Fax:	NDC : _ _ _ _ _
Drug Name: Strength:	
Dosage Instructions: Quantit	ty: Days Supply:
Length of Therapy on Prescription (Date Range):	
Diagnosis:	
Previous therapy (include drug name(s), strength and exact date ranges):	
Pertinent Lab Data:	
Other medical conditions to consider:	
Possible drug interactions/conflicting drug therapies:	
Attach lab results and other documentation as necessary.	
Prescriber Signature:	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.

*MUST MATCH PRESCRIBER LISTED ABOVE