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 the Iowa Medicaid 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, PRODUCT PROBLEM

1. Check all that apply
☐ Adverse Event
☐ Product Use Error
☐ Product Problem (e.g., defects/malfunctions)
☐ Problem with Different Manufacturer of Same Medicine

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

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

5. Describe Event, Problem, or Product Use Error; Relevant History & Tests

C. SUSPECT MEDICATIONS

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

#1 _____

#2 _____

2. Dose, Frequency & Route Used	3. Therapy Dates
#1 _____	#1 _____
#2 _____	#2 _____
4. Diagnosis for Use (Indication)	**5. Event Abated After Use Stopped or Dose Reduced?**
#1 _____	#1 ☐ Yes ☐ No ☐ N/A
#2 _____	#2 ☐ Yes ☐ No ☐ N/A
6. Lot # (if known)	**7. Event Reappeared After Reintroduction**
#1 _____	#1 ☐ Yes ☐ No ☐ N/A
#2 _____	#2 ☐ Yes ☐ No ☐ N/A

8. NDC # (specify generic manufacturer
#1 _____

#2 _____

D. OTHER (CONCOMITANT) MEDICAL PRODUCTS

Product names and therapy dates (exclude treatment of event).

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