Iowa Department of Human Services

Request for Prior Authorization
ALPHA$_2$ AGONISTS, EXTENDED-RELEASE

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

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

Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for extended-release alpha$_2$ agonists. Payment will be considered for patients when the following is met: 1) The patient has a diagnosis of ADHD and is between 6 and 17 years of age. 2) Previous trial with the preferred immediate release product of the same chemical entity at a therapeutic dose that resulted in a partial response with a documented intolerance; and 3) Previous trial and therapy failure at a therapeutic dose with one preferred amphetamine and one preferred non-amphetamine stimulant. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Preferred (no PA required)
☐ Guanfacine ER

Non-Preferred (PA required)
☐ Clonidine ER ☐ Intuniv ☐ Kapvay

Strength _____ **Dosage Instructions** _____ **Quantity** _____ **Days Supply** _____

Diagnosis: _____

Trial of preferred immediate release product of same chemical entity: Drug Name & Dose: _____ Trial Dates: _____ Failure Reason: _____

Trial of preferred amphetamine stimulant: Drug Name & Dose: _____
Trial Dates: _____ Failure Reason: _____

Trial of preferred non-amphetamine stimulant: Drug Name & Dose: _____
Trial dates: _____ Failure Reason: _____

Medical or contraindication reason to override trial requirements: _____

Attach lab results and other documentation 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.*