

This form is used for both preferred and non-preferred agents
(PLEASE PRINT – ACCURACY IS IMPORTANT)

Designated drugs are limited to a fifteen day initial supply. These drugs have been identified with high side effect profiles, high discontinuation rates, or frequent dose adjustments. The initial prescription supply limit ensures cost effectiveness without waste of unused medications. These drugs are identified on the Fifteen Day Initial Prescription Supply Limit list located on the website www.iowamedicaidpd.com under the Preferred Drug Lists tab. Documentation of medical necessity, excluding patient convenience, is required for consideration of the fifteen day initial supply override.

<u>Drug Name</u>	<u>Strength</u>	<u>Dosing Instructions</u>	<u>Quantity</u>
------------------	-----------------	----------------------------	-----------------

Diagnosis: _____

Medical Necessity Documentation:

Please note: reasons other than patient convenience are required.

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.