Iowa Department of Human Services

Request for Prior Authorization
SELECTED BRAND NAME DRUGS

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 fill 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 selected brand-name drugs, as determined by the Department, for which there is available an "A" rated bioequivalent generic product as determined by the Federal Food and Drug Administration, unless the brand drug has been designated by the Department as preferred (payable) under the Iowa Medicaid Preferred Drug List (PDL). For prior authorization to be considered, the prescriber must submit a completed Selected Brand-Name Drugs PA form and Iowa Medicaid MedWatch form with:

1. **Documentation of trials and therapy failures with two different generic manufacturers of the same chemical entity. If an allergy to an inactive component is suspected, the second trial must be with a generic product that does not contain the allergen, if available.**
2. **Documentation of the failure must include the specific adverse reaction as defined by the FDA (See Section B of the MedWatch form). Intolerances, such as nausea or vomiting, to the generic drug will not be considered as a basis for approval.**

Trials may be overridden when evidence is provided that use of the generic product would be medically contraindicated.

Drug Name:_____ **Strength:**_____

Dosage Instructions:_____ **Quantity:**_____ **Days Supply:** _____

Diagnosis:_____

Previous therapy (include drug name(s), manufacturer/labeler, strength, exact date ranges, and specific failure reason):**** To be documented on MedWatch form***

Other relevant information:_____

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.*

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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