Iowa Department of Human Services

Request for Prior Authorization
Duplicate Therapy Edit Override

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

A prior authorization is required for duplicate therapy for designated therapeutic classes.

Medications:

Drug name & strength:_____ Dosing instructions:_____
Quantity:_____ Days supply:_____ Date therapy initiated:_____

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Diagnosis:_____

Medical necessity for concurrent therapy:_____

_____

Anticipated length of concurrent therapy:_____

Proposed drug tapering schedule (if applicable):_____

_____

Reason for use of non-preferred drug requiring prior approval:_____

_____

Other medical conditions to consider:_____

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.*