Iowa Department of Human Services

Request for Prior Authorization
NONSTEROIDAL ANTI-INFLAMMATORY 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 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 all non-preferred nonsteroidal anti-inflammatory drugs (nsaids) and COX-2 inhibitors. Prior authorization is not required for preferred nsaids or COX-2 inhibitors. 1. Requests for a non-preferred nsaid must document previous trials and therapy failures with at least three preferred nsaids. 2. Requests for a non-preferred COX-2 inhibitor must document previous trials and therapy failures with three preferred nsaids, two of which must be preferred COX-2 preferentially selective nsaids. 3) Requests for a non-preferred extended release nsaid must document previous trials and therapy failures with three preferred nsaids, one of which must be the preferred immediate release nsaid of the same chemical entity at a therapeutic dose that resulted in a partial response with a documented intolerance. **The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.**

Preferred (No PA required)

Diclofenac Sod./Pot.
Diclofenac Sod. EC/DR
Etodolac 400mg/500mg
Flurbiprofen
Ibuprofen
Ibuprofen Susp.
Indomethacin
Ketoprofen
Meloxicam (COX-2)
Nabumetone (COX-2)
Naprosyn Susp.
Naproxen
Naproxen EC/ER
Naproxen Sodium 550mg
Pennsaid
Salsalate
Sulindac
Voltaren Gel

Non-Preferred (PA required for all products)

☐ Arthrotec
☐ Celebrex
☐ Celecoxib
☐ Diclofenac ER/XR*
☐ EC-Naprosyn
☐ Etodolac CR/ER/XR
☐ Fenoprofen
☐ Flector Patch
☐ Indomethacin ER*
☐ Ketoprofen ER
☐ Meclofenamate Sod
☐ Naprelan
☐ Oxaprosin
☐ Piroxicam
☐ Ponstel
☐ Tivorbex
☐ Tolmetin Sod
☐ Vivlodex
☐ Voltaren XR
☐ Zipsor
☐ Zorvolex
☐ **Other** (specify) _____

Strength_____ **Dosage Instructions**_____**Quantity**_____ **Days Supply**_____

Diagnosis:_____
Preferred Drug Trial 1: Drug Name& Dose_____ Trial Dates:_____

Failure Reason_____

Preferred Drug Trial 2: Drug Name& Dose_____ Trial Dates:_____

Failure Reason_____
Preferred Drug Trial 3: Drug Name& Dose_____ Trial Dates:_____

Failure Reason_____

Medical Necessity for alternative delivery system: _____

Medical or contraindication reason to override trial requirements: _____

Reason for use of Non-Preferred drug requiring prior approval:_____

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.*