Iowa Prescription Drug Prior Authorization Request Form

Urgent/Standard:_____

Plan/Medical Group Fax#: 1-844-462-5169

TAT: 72 hours for urgent/5 calendar days for standard requests

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization request.

Patient Information: This must be filled out completely to ensure HIPAA compliance

First Name:	Last Name:	MI:	Phone Number:
Address:	City:	State:	Zip Code:
Date of Birth:	☐ Male ☐ Female	Circle unit of measure Height (in/cm):_____Weight (lb/kg):_____	Allergies:
Patient's Authorized Representative (if applicable):		Authorized Representative Phone Number:	

Insurance Information

Primary Insurance Name:	Patient ID Number:
Secondary Insurance Name:	Patient ID Number:

Prescriber Information

First Name:	Last Name:	Specialty:	
Address:	City:	State:	Zip Code:
Requestor (if different than prescriber):		Office Contact Person:	
NPI Number (individual):		Phone Number:	
DEA Number (if required):		Fax Number (in HIPAA compliant area):	
Email Address:			

Medication / Medical and Dispensing Information

Medication Name:

☐ New Therapy ☐ Renewal

If Renewal: Date Therapy Initiated: Duration of Therapy (specific dates):

How did the patient receive the medication?

☐ Paid under Insurance Name:_____Prior Auth Number (if known):_____

☐ Other (explain):

Dose/Strength:	Frequency:	Length of Therapy/#Refills:	Quantity:

Administration:

☐ Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Other:

Administration Location:

☐ Patient's Home ☐ Long Term Care

☐ Physician's Office ☐ Home Care Agency ☐ Other (explain):_____

☐ Ambulatory Infusion Center ☐ Outpatient Hospital Care _____

PLEASE FAX COMPLETED FORM TO 1-844-462-5169

PRESCRIPTION DRUG PRIOR AUTHORIZATION REQUEST FORM

Patient Name:	ID#:

1. Has the patient tried any other medications for this condition? _YES (if yes, complete below) _NO		
Medication/Therapy (Specify Drug Name and Dosage)	**Duration of Therapy** (Specify Dates)	**Response/Reason for Failure/Allergy**

2. List Diagnoses:	**ICD-9/ICD-10:**

3. Required clinical information - Please provide all relevant clinical information to support a prior authorization review.

Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if patient has any contraindications for the health plan/insurer preferred drug. Lab results with dates must be provided if needed to establish diagnosis, or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage (e.g. formulary tier exceptions) or required under state and federal laws.

Attachments

☐

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date**:_____

To our providers: Our electronic prior authorization (ePA) process is the preferred method for submitting pharmacy prior authorization requests. Creating an account is free, easy and helps patients get their medications sooner. You can complete the process through your current electronic health record/electronic medical record (EHR/EMR) system or by using one of these ePA sites:

- CenterX (Epic: ePA workflow is automated during the order entry process)
- CoverMyMeds (https://www.covermymeds.com/main/prior-authorization-forms/)
- Surescripts (http://providerportal.surescripts.net/providerportal)

To determine which medications require prior authorization: **https://www.ingenio-rx.com/members/drug-lists-and-pharmacy-tools**

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