AmeriHealth Caritas Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization

Request for Quantity Limit Override

This form is used for both preferred and non-preferred agents.

Form applies to IA Health Link and ***hawk-i*** plans.

Please print – accuracy is important.

Fax completed form to 1-855-825-2714. Provider Help Desk: 1-855-328-1612.

AmeriHealth Caritas Iowa member ID #:		Patient name:	
Patient address:			DOB:
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:

Please note: AmeriHealth Caritas Iowa uses Iowa Medicaid Enterprise criteria. For complete criteria, please consult www.iowamedicaidpdl.com/pa_criteria.

Drug Name: Strength: Dosing Instructions: Quantity:

Diagnosis:

Medical Necessity Documentation (Required)

☐ **Quantity Limit Override:**
At least one criteria required (please submit supporting chart notes)

☐ Prior trial of drug at the manufacturer recommended dosing regimen failed (describe and include approximate dates):

☐ Patient unsuitable for a trial with the manufacturer recommended dosing regimen due to (describe):

☐ Patient needs titration of dose, but will eventually be on the manufacturer recommended dosing regimen:

☐ Patient is taking concomitant metabolism-inducing medication (describe):

☐ Patient shown to be a rapid extensive or ultra rapid metabolizer at CYP2D6 (describe):

☐ Patient was on high dose at time of transfer and records not available for rationale or has a long history of high dose usage (Will allow a two month approval for titration to an FDA approved dose):

☐ Other Reason (describe):

Attach lab results and other documentation as necessary.

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further attest that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.	
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.

Check www.amerihealthcaritasia.com/Provider to confirm your version of this form.