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CONTAINS CONFIDENTIAL PATIENT INFORMATION

New-to-Market Drugs

Prior Authorization of Benefits (PAB) Form

Complete form in its entirety and fax to:
Prior Authorization of Benefits Center at 1-844-512-9004
Provider Help Desk 1-800-454-3730

1. Patient information	2. Physician information
Patient name: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #: _____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication	4. Strength	5. Directions	6. Quantity per 30 days
	_____	_____	Specify: _____

7. Diagnosis: _____

8. Approval criteria: CHECK ALL BOXES THAT APPLY

Note: Any areas not filled out are considered not applicable to your patient and MAY AFFECT THE OUTCOME of this request.

Prior authorization is required for new-to-market drugs not yet reviewed by the Iowa Medicaid Pharmaceutical & Therapeutics (P&T) Committee. Payment will be considered for patients when the following criteria are met:

1) Patient has an FDA approved or compendia indication for the requested drug; and
2) If the requested drug falls in a therapeutic category/class with existing prior authorization criteria, the requested drug must meet the criteria for the same indication; or
3) If no clinical criteria are established for the requested drug, patient has tried and failed at least two preferred drugs, when available, from the Iowa Medicaid Preferred Drug List (PDL) for the submitted indication; and
4) Request must adhere to all FDA approved labeling.

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Once new-to-market drugs are reviewed by the P&T Committee, they will be placed on the PDL which will dictate ongoing PA criteria, if applicable.

Drug name: _____ Strength: _____

Dosage instructions: _____ Quantity: _____ Day's supply: _____

Diagnosis: _____

Preferred drug trial 1: Drug name/dose: ___

Trial start date: _____ Trial end date: _____

Reason for failure: _____

PAGE 1 OF 2, CONTINUED ON PAGE 2

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Patient name:_____ **Patient ID #:** _____

Preferred drug trial 2: Drug name/dose: __
_____ Trial start date:
_____Trial end date:_____
Reason for failure:_____

Pertinent lab data: _____

Other medical conditions to consider: _____
_____

Other relevant information: _____

Possible drug interactions/conflicting drug therapies: _____

Attach lab results and other documentation as necessary.

Patient name:_____ **Patient ID #:** _____

9. Physician signature

_____ _____
Prescriber or authorized signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.