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CONTAINS CONFIDENTIAL PATIENT INFORMATION

SELECTED BRAND NAME 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 selected brand-name drugs, as determined by the Department, for which there is available an "A" rated bioequivalent generic product as determined by the Federal Food and Drug Administration, unless the brand drug has been designated by the Department as preferred (payable) under the Iowa Medicaid Preferred Drug List (PDL). For prior authorization to be considered, the prescriber must submit a completed Selected Brand-Name Drugs PA form and Iowa Medicaid MedWatch form with:

1. **Documentation of trials and therapy failures with two different generic manufacturers of the same chemical entity. If an allergy to an inactive component is suspected, the second trial must be with a generic product that does not contain the allergen, if available.**
2. **Documentation of the failure must include the specific adverse reaction as defined by the FDA (See Section B of the MedWatch form). Intolerances, such as nausea or vomiting, to the generic drug will not be considered as a basis for approval.**

Trials may be overridden when evidence is provided that use of the generic product would be medically contraindicated.

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Prior Authorization of Benefits Center at 1-844-512-9004

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

Drug name:_____ **Strength:**_____ **Dosage instructions:**_____ **Quantity:**_____ **Days supply:** _____

Diagnosis: _____

Previous therapy (include drug name(s), manufacturer/labeler, strength, exact date ranges, and specific failure reason):*** *To be documented on MedWatch form***

Other relevant information: _____

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.

Iowa Medicaid MedWatch Form

Revised for submission of brand medically necessary requests for the Iowa Medicaid Pharmacy Program. Prescriber must have witnessed or has documentation that the manifestation of adverse event(s) is linked to generic drug. Completion of form does not automatically grant approval; incomplete forms will be returned with denial.***

A. PATIENT INFORMATION

Name:_____Sex: F

M Medicaid ID:_____DOB:_____/_____/_____

Weight:_____lbs Phone: (_____) _____

Has a generic been tried before? Yes No

Give date: _____/_____/_____ Age at time of event: _____

B. ADVERSE EVENT, PRODUCT PROBLEM

1. Check all that apply
   - Adverse Event
   - Product Use Error
   - Product Problem (e.g., defects/malfunctions)
   - Problem with Different Manufacturer of Same Medicine

2. Outcomes Attributed to Adverse Event: (Check all that apply.) Death:
   _____(month/day/year)
   - Disability or Permanent Damage
   - Life-threatening
   - Congenital Anomaly/ Birth Defects
   - Required Intervention to Prevent Permanent Impairment/Damage
   - Hospitalization – Initial or Prolonged
   - Other Serious (Important Medical Events)

3. Date of Event (mo/day/yr)	4. Date of This Report (mo/day/yr)

5. Describe Event, Problem, or Product Use Error; Relevant History & Tests

C. SUSPECT MEDICATIONS

1. Name (Give labeled strength & mfr/labeler, if known)

   #1 _____

   #2 _____

2. Dose, Frequency & Route Used	3. Therapy Dates
#1 _____	#1 _____
#2 _____	#2 _____
4. Diagnosis for Use (Indication)	5. Event Abated After Use Stopped or Dose Reduced?
#1 _____	#1 Yes No N/A
#2 _____	#2 Yes No N/A
6. Lot # (if known)	7. Event Reappeared After Reintroduction
#1 _____	#1 Yes No N/A
#2	#2 Yes No N/A

8. NDC # (specify generic manufacturer
   #1 _____

   #2 _____

D. OTHER (CONCOMITANT) MEDICAL PRODUCTS

Product names and therapy dates (exclude treatment of event).

E. REPORTER CERTIFICATION

Signature certifies that brand is medically necessary

Prescriber's Name _____

Signature _____NPI #_____

Address: _____

_____

Phone #: (_____)_____-_____ Fax

#: (_____)_____-_____ Did

the prescriber witness the ADR? Yes No

Has the ADR been previously reported to the FDA? Yes No

Please FAX form to the Iowa Medicaid Pharmacy Program at
1-844-512-9004
DO NOT fax directly to the FDA