

Request for Prior Authorization BENZODIAZEPINES



Provider Help Desk 1 (844) 236-1464

FAX Completed Form To 1 (877) 733-3195

(PLEASE PRINT – ACCURACY IS IMPORTANT)					
IA Medicaid Member ID #	Patient name			DOB	
Patient address					
Provider NPI	Prescriber na	ame		Phone	
Prescriber address	1			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 		
authorized in cases with documentation of previous trial and therapy failure with two preferred products. Prior authorization will be approved for up to 12 months for certain documented diagnoses and a 3 month period for all other diagnoses. If a long-acting medication is requested, one of the therapeutic trials must include the immediate release form of the requested benzodiazepine. The prescriber must review the patient's use of controlled substances on the lowa Prescription Monitoring Program website and determine if the use of a benzodiazepine is appropriate for this member. For patients taking concurrent opioids, the prescriber must document the following: I) The risks of using opioids and benzodiazepines concurrently has been discussed with the patient. 2) Documentation as to why concurrent use is medically necessary is provided. 3) A plan to taper the opioid or benzodiazepine is provided, if appropriate. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.					
Preferred Alprazolam Estazolam Chlordiazepoxide Clobazam Oxazepam Clonazepam Temazepa Clorazepate Diazepam	 n	Non-Preferred Ativan Alprazolam ER Alprazolam OD Clonazepam OD Dalmane Halcion		Temazepam 7.5/22.5mg Tranzene Triazolam Xanax Xanax XR	
Other (specify)					
Strength	Dosage Instruct	cions Qua	ntity Days Sup	oply	
Diagnosis: Generalized anxiety disorder Panic attack with or without agoraphobia Seizure Other (please specify)					
Trial I with preferred agent: Drug	Name		Strength		
Dosage instructions					
Trial 2 with preferred agent: Drug					
Dosage instructions					
Prescriber review of patient's controlled substances use on the Iowa PMP website: No Yes Date Reviewed:					

Is benzodiazepine use appropriate for patient based on PMP review?
No Yes

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Patients taking concurrent opioids:		
Have the risks of using opioids and benzodiazepines concurrently been discus	sed with the patient? No Yes	
Medical necessity for concurrent use:		
Provide plan to taper the opioid or benzodiazepine or medical rationale why	not appropriate:	
<u> </u>		
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.

PAA - 1016