

Iowa Department of Human Services Request for Prior Authorization Duplicate Therapy Edit Override



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 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		
A prior authorization is required for duplicate therapy for designated therapeutic classes.			
Medications:			
Drug name & strength:		Dosing instructions:	
Quantity: Days supply:		Date therapy initiated:	
Drug name & strength:			
Quantity: Days supply:		Date therapy initiated:	
Drug name & strength: Quantity: Days supply:			
Drug name & strength: Quantity: Days supply:			
Diagnosis:			
Medical necessity for concurrent therapy:			
Anticipated length of concurrent therapy:			
Proposed drug tapering schedule (if applicable):			
Reason for use of non-preferred drug requiring prior approval:			
Other medical conditions to consider:			
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			

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.