Iowa Health Link
IOWA HHS

MOLINA HEALTHCARE

Request for Prior Authorization
Initial Days' Supply Limit Override

Hawki
Iowa HHS

FAX Completed Form To
1 (877) 733-3195
Provider Help Desk
1 (844) 236-1464

(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	NDC

Requests for medications exceeding the initial days' supply limit require prior authorization (PA). Payment will be considered under the following conditions:

1. **Diagnosis is provided; and**
2. **Medical rationale for exceeding the initial days' supply limit is provided; and**
3. **Requests for opioids exceeding the 7 day initial supply limit will be considered:**
   a. **For patients with active cancer, patients experiencing acute sickle cell crises, end-of-life palliative care, or on an individual case-by-case basis based on medical necessity documentation provided; and**
   b. **Request must meet all other opioid requirements (quantity limits, morphine milligram equivalents (MME), and the preferred drug list (PDL). If requests do not comply with these requirements, separate, additional, PA is required. Please reference and use the following PA forms at www.iowamedicaidpdl.com where appropriate:**
      i. **Quantity Limit Override Form (exceeds established quantity limit)**
      ii. **High Dose Opioid PA Form (exceeds established MME limit)**
      iii. **Short-Acting Opioids PA Form (non-preferred short-acting opioids)**
      iv. **Long-Acting Opioids PA Form (non-preferred long-acting opioids); or**
4. **Requests for non-opioid drugs subject to the initial days' supply limit will be considered on an individual case-by-case basis, based on medical necessity documentation provided.**

Drug Name	Strength	Dosing Instructions	Quantity
_____	_____	_____	_____

Diagnosis: _____

Medical Necessity Documentation: _____

_____

_____

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.*