MOLINA HEALTHCARE
IOWA Provider Services
1 (844) 236-1464

Iowa Department of Human Services
REQUEST FOR QUANTITY LIMIT OVERRIDE
This form is used for both preferred and non-preferred agents
(PLEASE PRINT – ACCURACY IS IMPORTANT)

Iowa Health Link IOWA HHS Hawki Iowa HHS
FAX Completed Form To
1 (877) 733-3195

IA Medicaid
Member ID #: |___|___|___|___|___|___|___|___|___|___| Patient Name: _____ DOB: _____

Patient Address: _____

Provider NPI: |___|___|___|___|___|___|___|___|___|___| Prescriber Name: _____ Phone: _____
Prescriber Address: _____ Fax: _____

Pharmacy Name: _____ Address: _____ Phone: _____
Prescriber must fill all information above. It must be legible, correct and complete or form will be returned.
Pharmacy
NPI: |___|___|___|___|___|___|___|___|___|___| Pharmacy Fax: NDC : |___|___|___|___|___|___|___|___|___|___|

Drug Name	**Strength**	**Dosing Instructions**	**Quantity**

Diagnosis: _____

Medical Necessity Documentation (Required)

□ **Quantity Limit Override:**
At least one criteria required (please submit supporting chart notes)

- □ Prior trial of drug at the manufacturer recommended dosing regimen failed (describe and include approximate dates): _____
- □ Patient unsuitable for a trial with the manufacturer recommended dosing regimen due to (describe): _____
- □ Patient needs titration of dose, but will eventually be on the manufacturer recommended dosing regimen**:** _____
- □ Patient is taking concomitant metabolism-inducing medication (describe): _____
- □ Patient shown to be a rapid extensive or ultra rapid metabolizer at CYP2D6 (describe): _____
- □ was on high dose at time of transfer and records not available for rationale or has a long history of high dose usage (Will allow a two month approval for titration to an FDA approved dose): _____
- □ Other Reason (describe): _____

Prescriber Signature: _____ Date of Submission: _____
***MUST MATCH PRESCRIBER LISTED ABOVE**

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-1093