

G Iowa Health Link

Request for Prior Authorization EXTENDED RELEASE FORMULATIONS

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 inform	∣ ation above. It must be legible, correct, and c	omplete or fo	orm will be returned.	
Pharmacy NPI	Pharmacy fax	NDC		
approved labeling for requested precautions, drug interactions, a preferred immediate release pro- response with a documented inter preferred drug of a different cher overridden when documented even Prior Authorization is required for the for Cardura XL, Carvedilol ER, Coreg CR, Keppra XR, Lamictal XR, Luvox CR, M XR, pramipexole ER, pregabalin ER, F Trokendi XR, Ximino.	ested drug when the following conditions drug and indication, including age, dosin nd use in specific populations; and 2) Pr duct of the same chemical entity at a the oblerance; and 3) Previous trial and therap nical entity indicated to treat the submitte idence is provided that use of these age oblowing extended release formulations: Adoxa,, Doryx, Elepsia XR, Envarsus XR, Gabapentin E emantine ER, Mirapex ER, Motpoly XR, Moxata, rozac Weekly, Qudexy XR, Rayos, Requip XL, F	ng, contrain evious trial rapeutic dos oy failure at ed diagnosi nts would be Amoxicillin ER R, Glumetza, g, Namenda X Rythmol SR, Se	dications, warnings and and therapy failure with the se that resulted in a partial a therapeutic dose with a s. The required trials may be e medically contraindicated. c. Astagraf XL, Augmentin XR, Gocovri, Gralise, Kapspargo, (R, Oleptro, Osmolex ER, Oxtellar olodyn ER, topiramate ER,	
Drug Name:Strength:				
Dosage Instructions:	Quantity:D	ays Supply:		
Diagnosis:				
Previous therapy with immediate release product of same chemical entity (include strength, exact date ranges, and reason for failure)				
Previous therapy with a preferred drug of a different chemical entity (include strength, exact date ranges, and reason for failure):				
Contraindication(s) to using immediate release product and/or a preferred drug of a different chemical entity:				
Possible drug interactions/conflictir	g drug therapies:			
Attach lab recults and other dec				
Attach lab results and other doct	umentation as necessary.			
Prescriber signature (Must match pre	-	Date of sub	mission	