Provider Help Desk
1 (877) 776 –1567

FAX Completed Form To
1 (800) 574-2515

Iowa Department of Human Services

REQUEST FOR FIFTEEN DAY INITIAL PRESCRIPTION SUPPLY OVERRIDE

This form is used for both preferred and non-preferred agents

(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 fill all information above. It must be legible, correct and complete or form will be returned.

Pharmacy

NPI: |___|___|___|___|___|___|___|___|___|___| Pharmacy Fax: _____ NDC : |___|___|___|___|___|___|___|___|___|___|___|

Designated drugs are limited to a fifteen day initial supply. These drugs have been identified with high side effect profiles, high discontinuation rates, or frequent dose adjustments. The initial prescription supply limit ensures cost effectiveness without waste of unused medications. These drugs are identified on the Fifteen Day Initial Prescription Supply Limit list located on the website www.iowamedicaidpdl.com under the Preferred Drug Lists tab. Documentation of medical necessity, excluding patient convenience, is required for consideration of the fifteen day initial supply override.

Drug Name	Strength	Dosing Instructions	Quantity
_____	_____	_____	_____

Diagnosis:_____

Medical Necessity Documentation:

Please note: reasons other than patient convenience are required.

_____

_____

_____

_____

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.