iowa total care | ia health link | Hawki

FAX Completed Form To
1.833.404.2392
Prescriber Help Desk
1.833.587.2012
Online
covermymeds.com/main/prior-authorization-forms/

Request for Prior Authorization
NALOXONE NASAL SPRAY

(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

Prior authorization is required for a patient requiring more than 2 doses of naloxone nasal spray per 365 days. Requests for quantities greater than 2 doses per 365 days will be considered under the following conditions: 1) Documentation is provided indicating why patient needs additional doses of naloxone nasal spray (accidental overdose, intentional overdose, other reason); and 2) Naloxone nasal spray is to be used solely for the patient it is prescribed for; and 3) The patient is receiving an opioid as verified in pharmacy claims; and 4) Patient has been reeducated on opioid overdose prevention; and 5) Documentation is provided on the steps taken to decrease the chance of opioid overdose again; and 6) A treatment plan is included documenting a plan to lower the opioid dose.

Preferred

☐ Kloxxado ☐ Narcan ☐ Naloxone (labeler 00781)

Dosing instructions:_____ Quantity:_____ Days supply:_____

Most recent fill date:_____ Most recent date medication used:_____

Medical Necessity for Exceeding Quantity Limit:
☐ Intentional overdose ☐ Accidental overdose ☐ Other reason:_____

Will naloxone nasal spray be used solely for the patient it is prescribed for? ☐ Yes ☐ No

Is patient currently receiving an opioid as verified in pharmacy claims?
☐ No ☐ Yes, provide drug name and most current fill date:_____

Has patient been reeducated on opioid overdose prevention?
☐ No ☐ Yes, date provided:_____

Provide documentation on the steps taken to decrease the chance of opioid overdose again:_____

_____

_____

Provide treatment plan to lower opioid dose:_____

_____

_____

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 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.*