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
EXTENDED RELEASE FORMULATIONS
(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

Payment for a non-preferred extended release formulation will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met: 1) Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2) Previous trial and therapy failure with the preferred immediate release product of the same chemical entity at a therapeutic dose that resulted in a partial response with a documented intolerance; and 3) Previous trial and therapy failure at a therapeutic dose with a preferred drug of a different chemical entity indicated to treat the submitted diagnosis. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Prior Authorization is required for the following extended release formulations: Adoxa , Amoxicillin ER, Astagraf XL, Augmentin XR, Cardura XL, Carvedilol ER, Coreg CR, Doryx, Elepsia XR, Envarsus XR, Glumetza, Gocovri, Gralise, Kapspargo, Keppra XR, Lamictal XR, Luvox CR, Memantine ER, Mirapex ER, Motpoly XR, Moxatag, Namenda XR, Oleptro, Osmolex ER, Oxtellar XR, pramipexole ER, pregabalin ER, Prozac Weekly, Qudexy XR, Rayos, Requip XL, Rythmol SR, Solodyn ER, topiramate ER, Trokendi XR, Ximino.

Drug Name:_____ **Strength:**_____

Dosage Instructions:_____ **Quantity:**_____ **Days 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/conflicting drug therapies: _____

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 Health and Human Services, that the member continues to be eligible for Medicaid.*

Rev. 6/24