# Pharmacy Prior Authorization Form

INSTRUCTIONS:

1. Complete this form in its entirety. Any incomplete sections will result in a delay in processing.
2. We review requests for prior authorization based on medical necessity only. If we approve the request, payment is still subject to all general conditions of Amerigroup, including current member eligibility, other insurance and program restrictions. We will notify the provider and the member's pharmacy of our decision.
3. To help us expedite your Medicaid authorization requests, please fax all the information required on this form to 1-800-359-5781. All Medicare Part B authorization requests will need to be faxed to 1-866-959-1537.
4. Allow us at least 24 hours to review this request. If you have questions regarding a Medicaid prior authorization request, call us at 1-800-454-3730. The pharmacy is authorized to dispense up to a 72-hour supply while awaiting the outcome of this request. Please contact the member's pharmacy. If you have questions regarding Medicare Part B prior authorizations, please call us at 1-866-797-9884 option 5.
5. Access our website at providers.amerigroup.com to view the preferred drug list.
6. An ICD/Diagnosis code is required for all requests. An HCPCS billing code is required for all medical injectable/oncology requests. If the billing facility is different from the requesting physician, the billing facility information will need to be completed.

## Member Information

| Last name First name MI | Amerigroup ID # | Date of birth | Sex F☐ M☐ |
|---|---|---|---|
| Member's place of residence: ☐ Home ☐ Nursing facility<br>Administration site: ☐ Home ☐ Office ☐ Outpatient facility | Height | Weight | |

## Medication Information

| Drug name and strength requested: | SIG: (dose, frequency and duration) | HCPCS billing code |
|---|---|---|
| Diagnosis and/or indication: | | ICD code: |

| Has the member tried other medications to treat this condition? | Drug(s) name and strength: | |
|---|---|---|
| ☐ **Yes.** Provide this information in the area to the right. You may be asked to provide supporting documentation such as:<br>• Copies of medical records<br>• Office notes<br>• Complete FDA Medwatch form | Date range of use: | SIG: (dose and frequency) |
| ☐ **No. Explain why not:** _____ _____ _____ | Did the member experience any of the below?<br>☐ Adverse reaction ☐ Inadequate response ☐ Other<br>Briefly describe details of adverse reaction, inadequate response or other in the space provided below. | |

Describe medical necessity for nonpreferred medication(s) or for prescribing outside of FDA labeling:

List all current medications including dose and frequency:

Other pertinent information:

**Diagnostic Studies and/or Laboratory Tests Performed** (List all tests done within the past 30 days that are related to diagnosis of medication requested.)

| Labs: | | | | Diagnostic tests: | | |
|---|---|---|---|---|---|---|
| Test | Date | Result | | Procedure | Date | Result |
| | | | | | | |
| | | | | | | |

**Prescriber Information**

| Last name First name MI | | NPI# (required) | DEA/License # |
|---|---|---|---|
| Address where service was rendered | | City | State |
| ZIP code | Telephone number ( ) | Fax number ( ) | |
| Office contact name | | Contact direct phone number | |

**Billing Facility Information**

| Name | | NPI#/Tax ID (required) | DEA/License # |
|---|---|---|---|
| Address | | City | State |
| ZIP code | Telephone number ( ) | Fax number | Office contact name |

**Pharmacy Information**

| **Name** | **Pharmacy NPI #** | **Telephone number ( )** | **Fax Number ( )** |
|---|---|---|---|
| | | | |

**Signature**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission or concealment of material may be subject to civil or criminal liability.

Prescriber's signature (or authorized representative) Date