



**CONTAINS CONFIDENTIAL PATIENT INFORMATION**

**Age Limit**

**Prior Authorization of Benefits (PAB) Form**

**Complete form in its entirety and fax to:**

**Prior Authorization of Benefits Center at 1-844-512-9004**

**Provider Help Desk 1-800-454-3730**

**<https://providers.amerigroup.com>**

**1. PATIENT INFORMATION**

**2. PHYSICIAN INFORMATION**

Patient Name: _____	Prescribing Physician: _____
Patient ID #: _____	Physician Address: _____
Patient DOB: _____	Physician Phone #: _____
Date of Rx: _____	Physician Fax #: _____
Patient Phone #: _____	Physician Specialty: _____
Patient Email Address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician Email Address: _____

**3. MEDICATION**

**4. STRENGTH**

**5. DIRECTIONS**

**6. QUANTITY PER 30 DAYS**

_____	_____	_____	Specify: _____
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**7. DIAGNOSIS: \_\_\_\_\_**

**8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY**

**NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.**

The drug being requested is not recommended for a patient of this age, please indicate why this drug is being requested:

\_\_\_\_\_

\_\_\_\_\_

**9. PHYSICIAN SIGNATURE**

_____	_____
Prescriber or Authorized Signature	Date
<small>Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.</small>	
<small>Note: Payment is subject to member eligibility. Authorization does not guarantee payment.</small>	
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