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CONTAINS CONFIDENTIAL PATIENT INFORMATION

Topical Corticosteroids

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

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: _____

7. Diagnosis: _____

8. Approval criteria: CHECK ALL BOXES THAT APPLY

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

Prior authorization is required for nonpreferred topical corticosteroids. Payment will be considered for patients when there is documentation of adequate trials and therapy failures with at least two preferred, chemically distinct, topical corticosteroid agents within the same potency class or a higher potency class in the past 12 months. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Dosage form: _____

Days supply: _____

Preferred topical corticosteroid trial 1:

Drug name & dose: _____ Trial dates: _____

Failure reason: _____

PAGE 1 OF 2, CONTINUED ON PAGE 2

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Patient name:_____ **Patient ID #:** _____

Preferred topical corticosteroid trial 2:

Drug name & dose:_____ Trial dates: _____

Failure reason: _____

Medical or contraindication reason to override trial requirements: _____

_____

Attach lab results and other documentation as necessary.

Patient name:_____ **Patient ID #:** _____

9. Physician signature

_____ _____

Prescriber or authorized signature Date

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.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.