Amerigroup
An Anthem Company

TEXAS Health and Human Services

TEXAS Medicare Medicaid PLAN
Your Health Plan ★ Your Choice

Prior Authorization Form for Medical Injectables

If the following information is not complete, correct and/or legible, the prior authorization process can be delayed. Use one form per member.

Member information

Last name **First name**

Member ID number **Date of birth** - -

REQUIRED: Member information
☐ **Male** ☐ **Female** **Height** _____ **Weight**_____
Member's place of residence: ☐ Home ☐ Nursing facility
Administration location: ☐ Home ☐ Office ☐ Outpatient facility

Prescriber information

Last name **First name**

NPI **Tax ID**

Phone - - **Fax** - -

Prescriber information/demographics		
Address where service was rendered:	**City:**	**State:**
ZIP:	**Office contact name:**	**Contact direct phone number:**
Is the address above also the billing address? ☐ **Yes** ☐ **No** (If no, please complete the section below.)		

Billing facility information

Facility

NPI **DEA**

Contact person for billing facility

Last name **First name**

Phone - - **Fax** - -

Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Texas Medicaid to provide benefits of both programs to enrollees.

Medication information		
Drug name and strength requested:	**SIG (dose, frequency and duration):**	**HCPCS billing code:**
Diagnosis and/or indication:		**ICD code (required):**

Has the member tried other medications to treat this condition?

☐ Yes. Please provide this information in the area to the right. You may be asked to provide supporting documentation such as copies of medical records, office notes or a completed FDA MedWatch form.

☐ No. Explain why not:

_____
_____
_____
_____
_____

Drug(s) name and strength:

Date range of use:	**SIG (dose and frequency):**

Did member experience any of the below?

☐ Adverse reaction ☐ Inadequate response

☐ Other

Briefly describe details of the 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 the diagnosis or the medication requested.)

Labs			Diagnostic tests		
Test	**Date**	**Result**	**Procedure**	**Date**	**Result**

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 signature (required): _____ **Date:** _____

Fax this form to 1-844-494-8344.

For telephone prior authorization requests or questions, please call 1-855-878-1785.

Please allow Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) at least 24 hours to review this request.