Prior Authorization Form — Medical Injectables

If the following information is incomplete, incorrect, and/or illegible, the prior authorization (PA) process may be delayed. Please use one form per enrollee. Fax this form to **844-487-9294**. For telephone PA requests or questions, please call **800-454-3730**. Please allow Amerigroup District of Columbia, Inc. at least 24 hours to review this request.

Enrollee information

Last name		**First name**	

Amerigroup ID # _____ **DOB** _____

Enrollee information (required)

☐ Male ☐ Female Height _____ Weight _____

Enrollee's place of residence ☐ Home ☐ Nursing facility

Administration location facility ☐ Home ☐ Office ☐ Outpatient

Prescriber information/demographics

Last name		**First name**	

NPI # _____ # **Tax ID** _____

Phone # _____ **Fax #** _____

Address where service rendered	**City**	**State**

ZIP code	**Office contact name**	**Contact direct phone #**

Is the above address also the billing address? ☐ **Yes** ☐ **No (If no, please complete below.)**

Billing facility information

Facility name _____

NPI # _____ **DEA #** _____

Contact person for billing facility

Last name		**First name**	

Phone # _____ **Fax #** _____

Medication information

Drug name and strength requested	**SIG (dose, frequency, and duration)**	**HCPCS billing code**

Enrollee information

Diagnosis and/or indication	**ICD code (required)**

Medication information

Medication information

Has enrollee tried other medications to treat this condition?

☐ Yes — Provide this information in the adjacent table. You may be asked to provide supporting documentation such as copies of medical records, office notes or complete an FDA MedWatch form.

☐ No — Explain why not below.

_____
_____
_____
_____
_____
_____

Drug(s) name and strength	
Date range of use	**SIG (dose and frequency)**

Did enrollee experience any of the below?
☐ Adverse reaction ☐ Inadequate response ☐ Other

Briefly describe below any details of adverse reaction, inadequate response or other information.

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

List all current medications including dose and frequency.
_____
_____
_____

List other pertinent information.
_____
_____
_____

Diagnostic studies and/or laboratory tests performed — List all tests performed within the past 30 days that are related to the diagnosis for requested medication.

Labs				Diagnostic tests		
Test	Date	Result		Procedure	Date	Result

Prescriber signature (required): _____Date: _____

By signature, the prescriber confirms the above information is accurate and verifiable by patient records. The prescriber understands that any falsification, omission, or concealment of material may be subject to civil or criminal liability.