Amerigroup RealSolutions in healthcare

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:	
ID number:	DOB:	
Required		
☐ Male ☐ Female ☐ Other	Height:	Weight:
Member's place of residence: ☐ Home ☐ Nursing facility		
Administration location: ☐ Home ☐ Office ☐ Outpatient facility		
Requesting provider □ Contracted □ Noncontracted (Complete the information below if individual provider is *not* billing.)		
Last name:	First name:	Specialty:
NPI number:	Tax ID number:	
Office contact name:	Office phone:	Office fax:
Address:	City, state, and ZIP code:	
Servicing provider □ Contracted □ Noncontracted (Complete the information below if individual provider is billing.)		
Last name:	First name:	Specialty:
NPI number:	Tax ID number:	
Office contact name:	Office phone:	Office fax:
Address:	City, state, and ZIP code:	
Servicing facility □ Contracted □ Noncontracted (Complete the information below if the facility is billing.)		
Facility name:		
NPI number:	Tax ID number:	
Facility contact name:	Facility phone:	Facility fax:
Address:	City, state, and ZIP code:	

Medical information		
Drug name and strength requested:		
SIG (dose, frequency, and duration):		
HCPCS billing code(s):	ICD-10-CM code:	
Diagnosis and/or indication:		
Has member tried other medications to treat this condition? ☐ Yes, provide this information in the area below. You may be asked to provide supporting documentation such as copies of medical records, office notes, or complete *FDA MedWatch* form. ☐ No, explain why not:		
Drug name and strength:	Date range of use:	SIG (dose, frequency, and duration):
Did member experience any of the below? ☐ Adverse reaction ☐ Inadequate response ☐ Other 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 the diagnosis for medication requested.)					
Labs:			Diagnostic tests:		
Test	Date	Result	Test	Date	Result

Please attach any pertinent medical records required for review. 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 **844-490-4870**.

If you have any questions about this communication, contact Provider Services at **800-454-3730**.

Please allow Amerigroup Community Care at least 24 hours to review this request.