Medicaid

Prior Authorization Form: Medical Injectables

Member information

Last name	First name	Member ID	Date of birth
Required			
Member's place of residence: ☐ Home ☐ Nursing facility		Height	Weight
Administration site: ☐ Home ☐ Office ☐ Outpatient facility		☐ Male ☐ Female	

Prescriber information

Last name	First name	NPI (required)	Tax ID
Phone number		Fax number	

Prescriber information/demographics

Address where service was rendered		City
State	ZIP code	Telephone number
Office contact name		
Is the above address also the billing address? ☐Yes ☐ No (If no, please complete below)		

Billing facility information

Facility name	NPI/tax ID (required)	DEA/license

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
Diagnosis and/or indication:		ICD-10 code (required):

If the following information is not complete, correct and/or legible, the prior authorization (PA) process can be delayed. Please use one form per member and fax to **844-512-7026** once complete.

Continued on page 2 (required)

Has the member tried other medications to treat this condition? ☐ **Yes**, 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. • A completed *FDA MedWatch Form*. ☐ **No**, explain why not:	Drug name(s) and strength: Date range of use: / SIG code: (dose and frequency) Did the 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 diagnosis of medication requested.)

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

Signature

Prescriber's signature (required) Date

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

Fax this form to 844-512-7026 once complete.
For telephone PA requests or questions, please call 800-454-3730.
This form and PA criteria may be found by accessing https://provider.amerigroup.com/IA