



An Anthem Company

This PA form and PA criteria may be found by accessing <https://providers.amerigroup.com/TX>

Prior Authorization (PA) Form: Medical Injectables

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

Member information

Last name	<input type="text"/>	First name	<input type="text"/>
Amerigroup ID number	<input type="text"/>	Date of birth	<input type="text"/>

Member information	
REQUIRED	
<input type="checkbox"/> Male <input type="checkbox"/> Female	Height _____ Weight _____
Member's place of residence: <input type="checkbox"/> Home <input type="checkbox"/> Nursing facility	
Administration location: <input type="checkbox"/> Home <input type="checkbox"/> Office <input type="checkbox"/> Outpatient facility <input type="checkbox"/> Hospital	
Is the patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Prescriber information

Last name	<input type="text"/>	First name	<input type="text"/>
NPI #	<input type="text"/>	Tax ID #	<input type="text"/>
Phone	<input type="text"/>	Fax	<input type="text"/>

Prescriber information/demographics		
Address where service rendered:	City:	State:
ZIP code:	Office contact name:	Contact direct phone number:
Is the above address also the billing address? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, please complete below.)		

Billing facility information	
Facility name	<input type="text"/>
NPI #	DEA #

Contact person for billing facility

Last name	<input type="text"/>	First name	<input type="text"/>
Phone	<input type="text"/>	Fax	<input type="text"/>

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

Continued on page 2 (required)

Fax completed form to 1-844-512-8995.

For telephone PA requests or questions, please call 1-800-454-3730.

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

<p>Has the member tried other medications to treat this condition?</p> <input type="checkbox"/> 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 or complete FDA MedWatch form. <input type="checkbox"/> No: Explain why not.	Drug(s) name and strength:	
	Date range of use:	SIG: (dose and frequency)
	<p>Did member experience any of the below?</p> <input type="checkbox"/> Adverse reaction <input type="checkbox"/> Inadequate response <input type="checkbox"/> 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 for medication requested.)

LABS:			DIAGNOSTIC TESTS:		
TEST	DATE	RESULT	PROCEDURE	DATE	RESULT

(By signature, 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.)

Prescriber signature (REQUIRED):		Date:	
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Once complete, fax this form to 1-844-512-8995.
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