Amerigroup
An Anthem Company

Prior Authorization Form: Medical Injectables

This form and prior authorization (PA) criteria may be found by accessing https://providers.amerigroup.com.
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 | **First name**

Amerigroup Community Care ID number | **DOB** (– –)

REQUIRED

☐ **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 rendered:	**City:**	**State:**
ZIP code:	**Office contact name:**	**Contact direct phone number:**

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

Billing facility information

Facility name

NPI | **DEA no.**

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 code (REQUIRED)**

Continued on page 2 (required)

Fax this form to 1-844-509-9865.
For telephone PA requests or questions, please call 1-800-454-3730.
Please allow Amerigroup at least 24 hours to review this request.

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 or complete 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 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**

Prescriber signature (REQUIRED):_____Date: _____

(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.)

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