



Prior Authorization (PA) Form Medical Injectables

This PA form and PA Criteria may be found by accessing 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

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 _____
Administration location:		Member's place of residence:	
<input type="checkbox"/> Home	<input type="checkbox"/> Office	<input type="checkbox"/> Home	<input type="checkbox"/> Nursing Facility
<input type="checkbox"/> Outpatient Facility			

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 #	<input type="text"/>

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)	

please. ***Continued on Page 2 (Required)***

Fax This Form to 1-800-359-5781.

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

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

<p>This facsimile transmission contains legally privileged and confidential information intended for the parties identified below. If you have received this transmission in error, please immediately notify us by telephone and return the original message to 5800 Northampton Blvd., Norfolk, VA 23502. Distribution, reproduction or any other use of this transmission by any party other than the intended recipient is strictly prohibited.</p>



Prior Authorization (PA) Form Medical Injectables

This PA form and PA Criteria may be found by accessing providers.amerigroup.com

<p>Has member tried other medications to treat this condition?</p> <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.</p> <p><input type="checkbox"/> No: Explain why not:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Drug(s) name and strength:</p> <hr/> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;">Date range of use:</td> <td style="width: 50%; border: none;">SIG: (dose and frequency)</td> </tr> </table> <hr/> <p>Did member experience any of the below?</p> <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.</p> <p>_____</p> <p>_____</p>	Date range of use:	SIG: (dose and frequency)
Date range of use:	SIG: (dose and frequency)		

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.)

Fax This Form to 1-800-359-5781.

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

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

This facsimile transmission contains legally privileged and confidential information intended for the parties identified below. If you have received this transmission in error, please immediately notify us by telephone and return the original message to 5800 Northampton Blvd., Norfolk, VA 23502. Distribution, reproduction or any other use of this transmission by any party other than the intended recipient is strictly prohibited.