Amerigroup RealSolutions in healthcare

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Prior Authorization (PA) Form for Medical Injectables

This PA form and PA criteria may be found at https://providers.amerigroup.com. If the following information is not complete, correct and/or legible the PA process can be delayed. Please use one form per member. Please allow Amerigroup at least 24 hours to review this request. For telephone requests or questions, please call 1-800-454-3730. **Fax this completed form to 1-844-509-9862.**

Member information:

Last name	First name	MI	Amerigroup ID	Date of birth	Sex (circle one) M F
Member's place of residence: ☐ Home ☐ Nursing facility Administration site: ☐ Home ☐ Office ☐ Outpatient facility			Height Weight		

Prescriber information:

Last name	First name	MI	NPI (required)	DEA/license
Address where service was rendered			City	
State / ZIP code		Telephone number ( )	Fax number ( )	
Office contact name			Contact direct phone number ( )	

Billing facility information:

Name			NPI/Tax ID (required)	DEA/license
Address where service was rendered			City	
State	ZIP code	Telephone number ( )	Fax number ( )	
Office contact name				

Medication information:

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

Important note: You are not permitted to use or disclose Protected Health Information about individuals who you are not treating or are not enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.

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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: (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 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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