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 please.

Member Information

Last Name | **First Name**

Amerigroup ID Number | **Date of Birth** (__ __ – __ __ – __ __ __ __)

Member Information
****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 #**

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 1-855-363-0728.

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

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

Revised 03/01/2013

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Has 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:

_____

_____

<u>Diagnostic studies and/or laboratory tests performed</u> (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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