

## Prior Authorization (PA) Form: Medical Injectables

This form and 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	<input type="text"/>	First name	<input type="text"/>
Amerigroup Community Care ID number	<input type="text"/>	DOB	<input type="text"/>

#### \*\*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

### 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	<input type="text"/>	DEA no.	<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)

Continued on page 2 (required)

Fax this form to 1-844-490-4873.

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> <p><input type="checkbox"/> <b>Yes.</b> 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"/> <b>No.</b> Explain why not:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<b>Drug(s) name and strength</b>	
	<b>Date range of use</b>	<b>SIG (dose and frequency)</b>
	<p><b>Did member experience any of the below?</b></p> <p><input type="checkbox"/> Adverse reaction    <input type="checkbox"/> Inadequate response    <input type="checkbox"/> Other</p> <p>Briefly describe the details of the adverse reaction, inadequate response or other in the space provided below:</p> <p>_____</p> <p>_____</p> <p>_____</p>	

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 related to the diagnosis for the 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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