

Maryland Pharmacy Prior Authorization Form

Instructions:

1. Complete this form in its entirety. Any incomplete sections will result in a delay in processing.
2. We review requests for prior authorization based on medical necessity only. If we approve the request, payment is still subject to all general conditions of Amerigroup Community Care, including current member eligibility, other insurance and program restrictions. We will notify the provider and the member's pharmacy of our decision.
3. To help us expedite your Medicaid authorization requests, please fax all the information required on this form to 1-844-490-4871 for Retail and 1-844-490-4873 for Medical Injectable. Fax all Medicare Part B authorization requests to 1-866-959-1537.
4. Allow us at least 24 hours to review this request. If you have questions regarding a Medicaid prior authorization request, call us at 1-800-454-3730. The pharmacy is authorized to dispense up to a 72-hour supply while awaiting the outcome of this request. Please contact the member's pharmacy. If you have questions regarding Medicare Part B prior authorizations, please call us at 1-866-797-9884, option 5.
5. Access our website at <https://providers.amerigroup.com/MD> to view the *Preferred Drug List*.
6. An ICD/diagnosis code is required for all requests. An HCPCS billing code is required for all medical injectable/oncology requests. If the billing facility is different from the requesting physician, the billing facility information will need to be completed.

Member information

| | | | | | |
|--|------------|----|---------------|--------|------------------------------|
| Last name | First name | MI | Amerigroup ID | DOB | Sex (circle one) F M |
| Member's place of residence: <input type="checkbox"/> Home <input type="checkbox"/> Nursing facility | | | Height | Weight | |
| Administration site: <input type="checkbox"/> Home <input type="checkbox"/> Office <input type="checkbox"/> Outpatient facility | | | | | |

Medication information

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

| | | |
|---|---|--------------------------|
| Has the member tried other medications to treat this condition? <input type="checkbox"/> Yes. Provide this information in the area to the right. You may be asked to provide supporting documentation such as: <ul style="list-style-type: none"> Copies of medical records. Office notes. Complete FDA Medwatch form. <input type="checkbox"/> No. Explain why not: _____ _____ _____ | Drug(s) name and strength <hr/> | |
| | Date range of use | SIG (dose and frequency) |
| | Did the member experience any of the below? <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: _____ _____ _____ _____ | |

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 |
| | | | | | |
| | | | | | |

Prescriber information

| | | | | |
|------------------------------------|------------------------|----|-----------------------------|-----------------|
| Last name | First name | MI | NPI (required) | DEA/license no. |
| Address where service was rendered | | | City | State |
| ZIP code | Phone number () | | Fax number () | |
| Office contact name | | | Contact direct phone number | |

Billing facility information

| | | | |
|----------|------------------------|-----------------------|---------------------|
| Name | | NPI/tax ID (required) | DEA/license no. |
| Address | | City | State |
| ZIP code | Phone number () | Fax number | Office contact name |

Pharmacy information

| | | | |
|------|--------------|----------------------------|----------------------|
| Name | Pharmacy NPI | Telephone number () | Fax number () |
|------|--------------|----------------------------|----------------------|

Signature

I certify the information provided is accurate and complete to the best of my knowledge, and I understand any falsification, omission or concealment of material may be subject to civil or criminal liability.

Prescriber's signature (or authorized representative)

Date