

New Jersey Pharmacy Prior Authorization Form

Instructions:

Complete this form in its entirety. Any incomplete sections will result in a delay in processing. 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. To help us expedite your Medicaid authorization requests, please fax all the information required on this form to 1-844-509-9863 for retail pharmacy or 1-844-509-9865 for medical injectables. All Medicare Part B authorization requests will need to be faxed to 1-866-959-1537.

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.

Access our website at <https://providers.amerigroup.com> to view the *Preferred Drug List*. 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 #	Date of birth	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 <i>FDA Medwatch Form</i>. <input type="checkbox"/> No. Explain why not: <hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> <hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> <hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/>	Drug(s) name and strength:		
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Date range of use:</td> <td style="width: 50%;">SIG (dose and frequency):</td> </tr> </table>	Date range of use:	SIG (dose and frequency):
	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 #
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	City	State
ZIP code	Telephone number ()	Fax number Office contact name

Pharmacy information

Name	Pharmacy NPI #	Telephone number ()	Fax number ()
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Signature

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

 Prescriber's signature (or authorized representative)

 Date