Amerigroup

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 _____ **First name** _____

Amerigroup ID number _____ **DOB** _____

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 1-844-493-9209.

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

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

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 or a complete *FDA MedWatch Form*. ☐ **No.** Explain why not:	**Drug(s) name 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 the 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 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 any falsification, omission or concealment of material may be subject to civil or criminal liability.)

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