https://providers.amerigroup.com

Prior Authorization Form: Medical Injectables

Member information

Last name: | | | | | | | | | | | | | | | **First name:** | | | | | | | | | | | | |

Amerigroup Iowa, Inc. ID #: | | | | | | | | | | **Date of birth:** | | – | | | – | | | | |

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):**

If the following information is not complete, correct and/or legible, the prior authorization (PA) process can be delayed.
Please use one form per member and fax to 1-844-512-7026 once complete.

Continued on page two (required)

Please allow Amerigroup 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 below. _____ _____ _____ _____ _____	**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: _____

_____

Diagnostic studies and/or laboratory tests performed
(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.

Fax this form to 1-844-512-7026 once complete.

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

This form and PA criteria may be found by accessing providers.amerigroup.com/ia.