



AmeriHealth

Prior Authorization Form

Medicare Administrative Prior authorization for Part B/D coverage

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Date: _____ Patient ID #: _____ DOB: _____

Patient Name: _____ Provider NPI: _____

Prescribing Physician: _____ Office Contact: _____

Office Fax#: _____ Office Phone #: _____

Drug Requested AND Diagnosis

Hepatitis B Vaccine

High or Intermediate Risk, diagnosis code: _____

Other (please provide diagnosis and code): _____

Intravenous Immune Globulin (IVIG)

Primary Immunodeficiency, diagnosis code: _____

Other, diagnosis and code: _____

Nebulized solutions. Please circle drug: acetylcysteine (Mucomyst®), albuterol (Accuneb®, Proventil®), cromolyn (Intal®), DuoNeb®, ipratropium, metaproterenol (Alupent®), Pulmicort® Respules, Pulmozyme®, TOBI®, Xopenex®

For use in a nebulizer

Other (please describe and provide diagnosis code): _____

Immunosuppressants. Please circle drug: Cellcept®, Imuran®, cyclosporine (Neoral®, Sandimmune®, Gengraf®), Rapamune®, and Prograf®

Transplant, date of transplant: _____

Transplant paid by Medicare? Yes No

Other (please provide diagnosis code): _____

Erythropoietin. Please circle drug: Aranesp®, Epogen®, Procrit®

Anemia with Chronic Renal Failure, diagnosis code: _____

Is member currently on Dialysis? Yes No

Other (please provide diagnosis and code): _____

(pending approval) deliver to: Physician's office Member's home Office supply (NO AUTH. REQUIRED)

Please add any other supporting medical information that may be useful in the decision-making process:

FAX TO (888) 671-5285. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL

Internal use only

Document # _____ Coverage effective date / / _____

M F Rx coverage Y N LOB _____ Processor Initials _____

Previous Auth Y N STANDARD - SELECT Date _____

Approved B D **Reviewer Initials** _____ **Date** _____