AmeriHealth NEW JERSEY

FAX TO (888) 671-5285.
Your office will receive a response via fax or mail.

Future Scripts® General Prior Authorization Form

ONLY COMPLETED REQUESTS WILL BE REVIEWED		
Drug Requested (one drug per form only):	Quantity (qty. edit only):	
Date:	Patient ID#:	DOB:
Patient Name:	Provider NPI:	
Prescribing Physician:	Office Contact:	
Office Fax #:	Office Phone:	

ONLY COMPLETED REQUESTS WILL BE REVIEWED ***MEDICARE PART D ONLY: REQUESTS FOR OFF-LABEL USE REQUIRE SUPPORTING LITERATURE***

1. PROVIDER SPECIALTY (specify all)

2. DIAGNOSIS FOR DRUG REQUESTED (specify all)

3. MEDICATION HISTORY (Please list any previous or current therapy related to the diagnosis, using drug names and dates below)
☐ N/A If none or not applicable to diagnosis, indicate "N/A."

Drug Name	Date	Duration

a. Is the patient currently not compliant on the regiment specific to the diagnosis? ☐ Yes ☐ No ☐ N/A
Please add any other supporting medical information that may be useful in the decision-making process:

_____

_____

_____

_____

INTERNAL USE ONLY				
Coverage effective date:				
Document #:		Processor Initials:		Date:
Sex ☐ M ☐ F	Rx coverage ☐ Yes ☐ No	STANDARD - SELECT		LOB:
Previous Auth: ☐ Yes ☐ No		Approved:	Reviewer Initials:	Date:

FUTURE SCRIPTS Rx