AmeriHealth

General Prior Authorization Form

ONLY COMPLETED REQUESTS WILL BE REVIEWED

☐ Gender Edit ☐ Quantity Edit ☐ Age Edit ☐ Prior Authorization

Drug Requested _____ Quantity _____
(one drug per form only) (qty. edit only)

Date: _____ Patient ID#: _____ DOB:_____

Patient Name: _____ Provider NPI: _____

Prescribing Physician: _____ Office Contact: _____

Office Fax #: _____ Office Phone: _____

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******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)

☐ **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:

_____

_____

_____

_____

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

Internal use only **Coverage effective date / /**

Document #_____ Processor Initials_____ Date_____

M F Rx coverage Y N STANDARD - SELECT LOB_____

Previous Auth Y N **Approved** **Reviewer Initials**_____ Date_____

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