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)

Drug Name (dose and frequency)	Duration of therapy (include dates)	Currently prescribed	Compliant
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No

Please add any other supporting medical information that may be useful in the decision-making process including contraindications to medications related to the diagnosis:

_____

_____

_____

_____

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