AmeriHealth

Today's date: _____ **Date medication needed:** _____

Prior Authorization Form

Direct Ship General Drug Request – Medical Benefit Drugs Only

IF YOU ARE ORDERING BOTULINUM TOXINS (BOTOX, DYSPORT, MYOBLOC, XEOMIN), NUCALA, PROLIA/XGEVA, STELARA, SYNAGIS, XOLAIR, OR MAKENA/17 ALPHA-HYDROXYPROGESTERONE CAPROATE, PLEASE DOWNLOAD THE APPROPRIATE DRUG-SPECIFIC FORM AT: www.amerihealth.com/directship.

USE THIS FORM TO REQUEST ALL OTHER DRUGS AVAILABLE THROUGH THE DIRECT SHIP DRUG PROGRAM.

THE COMPLETE LIST OF ALL DRUGS AVAILABLE THROUGH THIS PROGRAM IS AVAILABLE AT: www.amerihealth.com/pdfs/providers/pharmacy_information/direct_ship/direct-ship-injectables-list.pdf.

REQUESTS FOR DRUGS THAT ARE NOT ON THE DIRECT SHIP DRUG LIST (SEE ABOVE) WILL NOT BE PROCESSED.

ONLY COMPLETED REQUESTS WILL BE REVIEWED.

Drug being requested: _____ **Check one:** ☐ New start ☐ Continued treatment

Patient information (please print)			**Physician information (please print)**	
Patient name			Prescribing physician	
Address			Office address	
City, state, ZIP			City, state, ZIP	
Patient telephone #			Office contact	
Patient ID			Office telephone #	
Date of Birth	Weight	Height	Fax #	NPI

☐ **No delivery requested; physician will use office supply. Authorization only.**

☐ **Delivery requested to the physician's office.**

**** A copy of the prescription must accompany the medication request for delivery.****

1) **Physician specialty (specify all):** _____

2) **Diagnosis for drug requested (must include ICD-10):** _____

3) **Supporting member medical information/history**

Please add any member information that may be useful in the decision-making process.

_____

_____

4) **Prescription Information:**

Quantity_____ Refill x _____month(s)

Instructions (include dose) _____ every _____ day(s)/ week(s)/ month(s)

Physician's Signature: _____

Please fax this completed form to 215-761-9580.

03/15/2016