Medication Prior Authorization Request Form

**REQUIRED FIELDS: PA requests with missing/incomplete required fields may be returned as an invalid request. Valid requests also require appropriate clinical documentation to support the medical necessity of this request.*

Type of Request:
Select one

Today's Date: _____

I. MEMBER INFORMATION

***Name:** _____
ID Number: _____
Gender _____
***Date of Birth:** _____
Medication Allergies: _____
Member's Height: _____
Member's Weight: _____ ☐ kg ☐ lb. (select one)

II. PRESCRIBER INFORMATION

***Name:** _____
Specialty: _____
***NPI or DEA Number:** _____
***Phone:** _____
***Fax:** _____
Office Contact Name: _____

III. ADMINISTRATION

Site of Administration: _____ If other, specify: _____

If preferred administration site has a different address than the prescribing physician's practice above, please complete the following: _____

Name of Preferred Site of Administration or Home Infusion Company: _____

Contact Name: _____ Phone: _____ Fax: _____ NPI#: _____

IV. DRUG INFORMATION (only ONE drug request per form)

***HCPCS (if buy and bill):** _____ ***Drug Name:** _____
***Strength:** _____ ***Dosage Form:** _____
***Directions for Use (sig):** _____
***Therapy Start Date:** _____ ***Therapy End Date:** _____

V. DIAGNOSIS (as relevant to this request)

Diagnosis: _____ ***ICD10:** _____
Date of Diagnosis: _____ NOTE: Include diagnostic clinicals (labs, radiology, etc.).

VI. RATIONALE FOR REQUEST and PERTINENT CLINICAL INFORMATION

NOTE: Supporting documentation (such as office chart notes, lab results, prior therapy and other clinical information) is REQUIRED for consideration of approval.

X _____ **Date:** _____
Prescriber Signature

For a current listing of preferred products, visit AmbetterHealth.com or contact Provider Services at 1-877-687-1169.