

Today's date: _____

Intended date of injection: _____

Prior Authorization Form

Direct Ship General Drug Request – Medical Benefit Drugs Only

IF YOU ARE ORDERING BOTULINUM TOXINS (BOTOX, DYSPORT, MYOBLOC, XEOMIN), FASENRA, NUCALA, PROLIA/XGEVA, YESINTEK, VIVITROL, OR XOLAIR,

PLEASE DOWNLOAD THE APPROPRIATE DRUG-SPECIFIC FORM AT:

<https://www.ahatpa.com/html/health-care-providers/direct-ship-drug/index.html>

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 CAN BE FOUND AT:

<https://www.amerihealth.com/tpa/resources/for-providers/direct-ship-drug-program.html>

REQUESTS FOR DRUGS THAT ARE NOT ON THE DIRECT SHIP DRUG LIST 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.

Fax any additional information along with this form.

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