AmeriHealth ADMINISTRATORS

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, MAKENA/17 ALPHA-HYDROXYPROGESTERONE CAPROATE, NUCALA, PROLIA/XGEVA, STELARA, SYNAGIS, VIVITROL, OR XOLAIR, PLEASE DOWNLOAD THE APPROPRIATE DRUG-SPECIFIC FORM AT: https://www.ahatpa.com/html/providers/pharmacy/injectables.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.ahatpa.com/Resources/pdfs/7.4/7.4.4/direct_ship_drug_list.pdf.

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 215-784-0672.

1/23/2020

P.O. Box 21545 | Eagan, MN 55121