

Biopharmacy Outpatient

Prior Authorization Fax Form



Please fax this completed form to 1-866-683-5631.

Date of request: _____

Request to modify existing authorization (include authorization number): _____

Details of modification: _____

To the best of your knowledge this medication is: New therapy Continuation of therapy (approximate date therapy initiated): _____

Expedited/Urgent Review Requested. Signature of Prescriber or Prescriber's Designee: _____

Please note: By checking this box and signing above, I certify that applying the standard review time frame may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

*INDICATES REQUIRED FIELD

MEMBER INFORMATION

Member ID*	Date of Birth*	Member Phone Number
_____	_____	_____
Last Name*	First Name*	
_____	_____	

REQUESTING PROVIDER INFORMATION

Requesting NPI*	Requesting TIN*	Requesting Provider Contact Name	
_____	_____	_____	
Requesting Provider Name*	Specialty	Phone*	Fax*
_____	_____	_____	_____

SERVICING PROVIDER / FACILITY INFORMATION Same as Requesting Provider

Servicing NPI*	Servicing TIN*	Requesting Provider Contact Name	
_____	_____	_____	
Servicing Provider/Facility Name*	Specialty	Phone*	Fax*
_____	_____	_____	_____

AUTHORIZATION REQUEST

Primary Procedure Code*	Additional Procedure Code	Start Date OR Admission Date*	Diagnosis Code*
_____ (CPT/HCPSS)	_____ (CPT/HCPSS)	_____ (MMDDYYYY)	_____ (ICD-10)
(Modifier)	(Modifier)		
Additional Procedure Code	Additional Procedure Code	End Date OR Admission Date*	
_____ (CPT/HCPSS)	_____ (CPT/HCPSS)	_____ (MMDDYYYY)	
(Modifier)	(Modifier)		

MEDICATION REQUESTED

Medication Name*	Dose Per Visit*	Frequency*	Total Number of Visits*
_____	_____	_____	_____

Rationale for request and pertinent clinical information is required for all prior authorizations and should be attached to this request*

Maximize the number of visits to be calculated based on frequency and maximum length of approval duration, if allowed by criteria. Checking this box should not be used in lieu of filling out form completely.

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered benefit and medically necessary with prior authorization as per Ambetter policy and procedures.

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