AmeriHealth
NEW JERSEY

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.amerihealthnj.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.amerihealthnj.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 215-761-9580.**

4/15/2018

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