AVMED HEALTH PLAN

MEDICAL DRUG PRIOR AUTHORIZATION REQUEST

DATE OF REQUEST: _____ **PRIORITY:** ☐ Standard ☐ Urgent

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-877-535-1391**. No additional phone calls will be necessary if all information (including phone and fax numbers) on this form is correct. If information provided is not complete, correct, or legible, authorization may be delayed.

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

DELIVERY/ADMINISTRATION INFORMATION: Authorization may be delayed if incomplete.

☐ In-office (MD will supply and administer)

☐ Home Health Provider

☐ Outpatient Facility (Name of Facility _____Phone Number:_____)

☐ Infusion Suite (Name of Facility _____Phone Number:_____)

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name: _____

Drug Strength: _____ Route of Administration: _____ Dosage Quantity: _____

Dosing Schedule:_____

HCPCS/J-Code: _____

Length of Therapy: _____

If continuation of therapy, please indicate therapeutic response: _____

_____

_____

Diagnosis: _____ ICD Code: _____

Height: _____ Weight: _____ Date:_____

Please review and complete ALL fields on this form. Appropriate chart notes (including relevant lab work) MUST be submitted with ALL authorization requests. Previous therapies will be verified through pharmacy claims or submitted chart notes. Use of samples to initiate therapy does not meet the step therapy or preauthorization criteria.