MEDICARE MEDICATION PRIOR AUTHORIZATION REQUEST FORM

Date of Submission: _____

For a complete list of all medications that require a prior authorization, please visit AvMed's website at www.avmed.org/prescriptions

- **For medications administered in the physician's office, participating facility, or in the home by a healthcare practitioner, please select the following link: Prior Authorization Requirements (Office, Outpatient Facility, Home Health)**
- **For medications obtained at the pharmacy, please select the appropriate Medicare formulary from the list of Medicare Covered Drugs**

PATIENT INFORMATION					
Member ID	A	**Date of Birth**		**Is Member Pregnant?** ☐Yes ☐ No	
Member Name		**Height**		**Weight**	
Diagnosis		**Diagnosis (ICD-10) Code**			

Delivery – Administration information	
☐ **Retail Pharmacy Pickup**	☐ **Hospital – Outpatient Facility:**
☐ **In-office (MD to supply and administer)**	☐ **Non-Hospital Facility - Infusion Suite:**
☐ **In-Office Delivery** (Specialty Delivery Program Forms) **note:**	**If you are requesting medication delivery to your office, enrollment in the Specialty Delivery Program is required**

ADDITIONAL MEDICATION INFORMATION **FAX 305-671-0189**

Please attach all Office Notes and Current Lab Results

Incomplete forms and/or inadequate documentation may result in a denial

Drug Name		**Quantity**	
Directions for Use		☐ **New Therapy**	☐ **Continuation of Therapy**
If Continuation of Therapy, indicate the member's therapeutic response:			
Duration of Therapy		**Procedure Code**	
Reason for Request			

PHYSICIAN INFORMATION				
Prescriber Name		**Prescriber Specialty**		
Form Completed By		**AvMed Provider Id #**		
NPI #		**Office Number**		**Ext**
Contact Name		**Fax Number**		

Please remember to review and complete all fields on this form and include appropriate Office Notes and Labs with all requests

Fax completed form to AvMed at 1-877-535-1391 or 305-671-0189