PRIOR AUTHORIZATION REQUEST FOR MEDICAID MEMBERS

Injectable Medications (J-Codes)

Please fax form and required documents to Amida Care: 1-646-786-0997

Section I: MEMBER INFORMATION	
Name:	**Medicaid ID #:**
Phone #:	**Date of Birth:**
Height (in/cm):	**Weight (lb/kg):**

Section II: PRESCRIBER INFORMATION	
Name/Title:	**NPI:**
Office Phone #:	**Office Fax #:**
Address:	
Contact Person:	

Section III: MEDICATION REQUEST	
Please check one of the following regarding the medication: ☐ New Request ☐ Reauthorization	
Medication Name:	**Dose/ Strength:**
J Code:	**Total Units Requested:**
Date of request:	**Dosing Schedule:**
Date of Service: Start: End:	
Administration Route: ☐ Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Other:__________________	
Administration Location: ☐ Physician's Office ☐ Ambulatory Infusion Center ☐ Patient's Home ☐ Home Care Agency ☐ Outpatient Hospital Care ☐ Long Term Care ☐ Other (explain):_________________________	

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Previous medications prescribed and outcomes *(include medication, strength, dose, and date of administration):*

CLINICAL CRITERIA

******Please provide labs/documentation required for verification of questions******

Diagnoses (ICD10) :	**Changes to previous clinical condition**:

Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if patient has any contraindications for the health plan/insurer preferred drug. Lab results with dates must be provided if needed to establish diagnosis, or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage

Attach relevant lab results, tests, and diagnostic studies. **Check if attached** □

Additional Information

Please check one for each section below:

Indication:

□ The intended use of this medication is listed or identified as an accepted indication within the drug package insert or other resources.

□ The intended use of this medication is **NOT** listed as an accepted indication within drug package insert or other resources. **Peer-reviewed clinical literature must be attached.**

Dose:

□ The duration and dose of this medication are within standards of general prescribing and dosing limits for the intended use.

□ The duration and dose this medication are **NOT** within standards of general prescribing and dosing limits for the intended use. **Attach peer-reviewed literature indicating dose and duration is appropriate.**

Please call 646-757-7979, M-F, 9:00AM – 4:30PM with questions or additional information. You may also provide us with your contact information and the best time to reach you in the space at the top of this document.

____ ____/____/______

Prescriber or Authorized Signature Date