Infusible Biological Medications Prior Authorization Request Form
(i.e. Inflectra ®)

AmeriHealth Caritas
District of Columbia

Fax to Pharmacy Services at **855-811-9332** or call **888-602-3741**
to speak to a representative. ***Form must be completed for processing.***

Patient Name: _____ Patient ID #: _____

Address: _____ Apt # or Suite #: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Weight: _____lbs. =_____Kg Birth Date: _____

Physician Name: _____ NPI #: _____

Address: _____ Apt # or Suite #: _____

City: _____ State: _____ Zip Code: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Physician Signature: _____

Drug to be administered from (on): _____to _____ or was administered on: _____to be replaced.

The medication is being infused at (i.e. MD office, infusion center, hospital)-please give location type & name: _____

Has the member been evaluated for active or latent TB infection? ☐ YES ☐ NO Date of PPD (tuberculin skin test): _____

Drug: _____Dose: _____ Sig: _____

Diagnosis: _____ ICD-10 Diagnosis Code: _____

For coverage determination additional information is needed to proceed with review. Prior to receiving approval, the patient must have a documented medical reason to be unable to take therapeutic alternatives. Please identify the therapies attempted and document the dose, start date, end date and reasons for discontinuation (e.g. intolerance, hypersensitivity, and other medical reasons).

Drug	Dose	Start Date	End Date	Comments

Additional Comments: _____

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