AmeriHealth Caritas District of Columbia

HCPCS (Healthcare Common Procedure Coding System) Authorization Form

Confidential information

Patient name:		
Patient date of birth (MM/DD/YYYY): / /	Patient ID number:	
Physician name:	Specialty:	
Phone:	Fax:	NPI:
Physician street address:		
City:	State:	ZIP code:
Facility name:	Facility NPI:	
Treatment setting: ☐ Infusion Center ☐ Home ☐ Provider's office ☐ Hospital Outpatient facility		
Medication name and strength requested:	J-code: Number of units: Date of service (MM/DD/YYYY): / /	
Directions:		
Anticipated length of therapy: ☐ Days ☐ 3 months ☐ 6 months		
Diagnosis:		
Preferred medications tried/Previous therapy. Please include strength, frequency, and duration. (If medications were tried prior to enrollment, or if office samples were given, please include chart notes and/or sample logs.)		

Rationale for hospital outpatient facility treatment setting (if applicable):

☐ Documented history of severe adverse reaction occurred during or immediately following an infusion and/or the adverse reaction did not respond to conventional interventions

☐ Documentation that the member is medically unstable for the safe and effective administration of the prescribed medication at an alternative site of care as a result of one of the following:

☐ Complex medical condition, status, or therapy requires services beyond the capabilities of an office or home infusion setting (clinical instability or a complex regimen that requires frequent clinical assessment or monitoring, which would be beyond the capabilities of an office or home infusion setting)

☐ Documented history of medical instability, significant comorbidity, or concerns regarding fluid status inhibits treatment at a less-intensive site of care (unstable fluid status associated with heart failure or advanced (stage 4 or 5) renal failure)

☐ Clinically significant physical or cognitive impairment that precludes safe and effective treatment in an outpatient or home infusion setting (physical disability or disruptive or uncooperative behavior) ☐ Difficulty establishing and maintaining reliable vascular access	
Rationale and/or additional information that may be relevant to the review of this prior authorization request (If more space is needed, please attach an additional page to this document.)	
Physician signature:	Date (MM/DD/YYYY): / /

Please return this form Fax to**: 1-855-811-9332 or call 888-602-3741**