AmeriHealth Caritas Ohio

# HCPCS (Healthcare Common Procedure Coding System) Authorization Form

| Confidential information | | | |
|---|---|---|---|
| Patient name: | | | |
| Patient date of birth (MM/DD/YYYY): | | Patient ID number: | |
| Physician name: | | | |
| Physician Tax ID: | | Specialty: | |
| Phone: | Fax: | Physician NPI: | |
| Physician street address: | | | |
| City: | | State: | ZIP code: |
| Facility name: | | | |
| Facility NPI: | | Facility Tax ID: | |
| Facility street address: | | | |
| Facility city: | | State: | ZIP code: |
| Treatment setting: ☐ Infusion center ☐ Hospital outpatient facility ☐ Home infusion ☐ Provider's office ☐ Other: | | | |
| 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 ☐ Other: | | | |
| 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 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 fax this form to PerformRx:**
Standard fax: **1-855-839-3882**
Urgent fax: **1-833-498-1208**

PerformRx Provider Services: **1-855-662-0279**

PERFORMRx℠

ACOH_243429356-1