Biopharmacy Outpatient

Prior Authorization Fax Form

superior healthplan™

Please fax this completed form to 1-866-683-5631. Date of request: _____

☐ Request to modify existing authorization (include authorization number): _____

Details of modification: _____

To the best of your knowledge this medication is: ○ New therapy ○ Continuation of therapy (approximate date therapy initiated): _____

☐ Expedited/Urgent Review Requested. Signature of Prescriber or Prescriber's Designee: _____

Please note: By checking this box and signing above, I certify that applying the standard review time frame may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

***INDICATES REQUIRED FIELD**

MEMBER INFORMATION

Member ID* _____ Date of Birth* _____ Member Phone Number _____

Last Name* _____ First Name* _____

REQUESTING PROVIDER INFORMATION

Requesting NPI* _____ Requesting TIN* _____ Requesting Provider Contact Name _____

Requesting Provider Name* _____ Specialty _____ Phone* _____ Fax* _____

SERVICING PROVIDER / FACILITY INFORMATION ☐ *Same as Requesting Provider*

Servicing NPI* _____ Servicing TIN* _____ Requesting Provider Contact Name _____

Servicing Provider/Facility Name* _____ Specialty _____ Phone* _____ Fax* _____

AUTHORIZATION REQUEST

Primary Procedure Code* _____ (CPT/HCPSS) _____ (Modifier) Additional Procedure Code _____ (CPT/HCPSS) _____ (Modifier) Start Date OR Admission Date* _____ (MMDDYYYY) Diagnosis Code* _____ . _____ (ICD-10)

Additional Procedure Code _____ (CPT/HCPSS) _____ (Modifier) Additional Procedure Code _____ (CPT/HCPSS) _____ (Modifier) End Date OR Admission Date* _____ (MMDDYYYY)

MEDICATION REQUESTED

Medication Name* _____ Dose Per Visit* _____ Frequency* _____ Total Number of Visits* _____

Rationale for request and pertinent clinical information is required for all prior authorizations and should be attached to this request*

☐ Maximize the number of visits to be calculated based on frequency and maximum length of approval duration, if allowed by criteria. Checking this box should not be used in lieu of filling out form completely.

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered benefit and medically necessary with prior authorization as per Ambetter policy and procedures.

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