ARIZONA STANDARDIZED PRIOR AUTHORIZATION REQUEST FOR MEDICATION, DME, AND MEDICAL DEVICE

Pharmacy: Submit via portal Cover My Meds or Fax: 800.977.4170

Medical Drugs/J-Code/"buy-and-bill"/Medical Device/DME/O&P: Submit via AzCH Provider Portal or Fax: 866.597.7603

SECTION I – SUBMISSION

Subscriber Name:	Phone:	Fax:	Date:

SECTION II — REASON FOR REQUEST

Check One	☐ Initial Request	☐ Continuation/Renewal Request
Reason for request: (check all that apply below)	☒ Prior Authorization	
☐ Step Therapy, Formulary Exception		☐ Medical Device
☐ Quantity Exception		☐ Durable Medical Equipment (DME)
☐ Specialty Drug		☐ Other (please specify)
Ambetter Service Type Code *review table on bottom of page, choose applicable 3-digit code & add here*		

SECTION III — REVIEW

☐ **Expedited/Urgent Review Requested:** By checking this box and signing below, 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.

Signature of Prescriber or Prescriber's Designee: _____

SECTION IV — PATIENT INFORMATION

Name:	Phone:	DOB:	☐ Male ☐ Female
Address:	City:	State:	ZIP Code:
Subscriber Name (if different from Section I):	Member ID #:	Group Name or Number:	
BIN # (if available):	PCN (if available):	Rx ID # (if available):	

SECTION V — PRESCRIBER/ORDERING/SERVICING PROVDER INFORMATION

Requesting Prescribing/Ordering Provider or Facility			**Service Provider or Facility**		
Name:			Name:		
NPI:	TIN:	Specialty:	NPI:	TIN:	Specialty:
Phone:	Fax:		Phone:	Fax:	
Contact Name:	Phone:		Service Provider's Name:		
Requesting Provider's Signature & Date (if required):		Phone:		Fax:	

SECTION VI — PRESCRIPTION DRUG INFORMATION *(If this is a compound drug, identify all ingredients in Section VI, below.)*

Requested Drug Name:				
Strength:	Route of Administration:	Quantity:	Days' Supply:	Expected Therapy Duration:

To the best of your knowledge this medication is:

☐ New therapy ☐ Continuation of therapy (approximate date therapy initiated:)

For Provider Administered Drugs Only:

HCPCS Code: _____ NDC #: _____ Dose Per Administration: _____

Ambetter Service Type Code (add to designated field above)					
422	BioPharmacy (In-Office Injectable)	120	DME Purchase	147	Prosthetics
417	DME Rental	210	Orthotics		Pharmacy: Leave blank no code needed

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SECTION VII — PRESCRIPTION COMPOUND DRUG INFORMATION

Compound Drug Name:					
Ingredient	NDC #	Quantity	Ingredient	NDC #	Quantity

SECTION VIII — PRESCRIPTION, DME or MEDICAL DEVICE INFORMATION

Requested DME or Medical Device Name:	Expected Duration of Use:	HCPCS Code (If applicable):

SECTION IX — PATIENT CLINICAL INFORMATION

Patient's diagnosis related to this request:	ICD Version 10	ICD Code:
Patient's diagnosis related to this request:	ICD Version 10	ICD Code:

Drugs patient has taken for this diagnosis: *(Provide the following information to the best of your knowledge)*

Drug Name	Strength	Frequency	Dates Started and Stopped or Approximate Duration	Describe Response, Reason for Failure, or Allergy

Drug Allergies:	Height (if applicable):	Weight (if applicable):

Relevant laboratory values and dates (attach or list below):

Date	Test	Value

SECTION X — JUSTIFICATION (Provide or attach any additional justification here: Notes, Treatment plans, lab/test results, etc.)

 ALL REQUIRED FIELDS MUST BE COMPLETED TO AVOID A REJECTED FORM. COPIES OF SUPPORTING CLINICAL INFORMATION REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.