HCPCS (Healthcare Common Procedure Coding System) Authorization Form

AmeriHealth Caritas Next
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PerformRx℠

Fax to PerformRx℠ at **1-844-566-1661.** For urgent faxes: **1-833-984-7329.** To speak to a representative call **1-855-562-7287.**

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 street address:	Facility Tax ID:	
Facility city:	State:	ZIP code:
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:		
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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 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): / /