MEDICARE ADVANTAGE DRUGS/BIOLOGICS PART B PRECERTIFICATION FORM

This precertification form applies to Arizona health plans only.
Please fax to:**1-877-730-3858** | Phone: **1-888-454-0013**

☐ **Expedited – defined as danger to a patient's health if not provided within 24 hours**		
Patient name:		Patient date of birth:
Name of requesting provider:		ID number:
Contact person:		Date of service:
Address:		
NPI number:	Phone number:	Fax number:

If referring to a (servicing) provider, the below stated information must be submitted:	
Name of servicing provider:	Phone number:
Contact person:	Fax number:
Address:	NPI number:
☐ Please check if servicing provider is non-contracted If servicing provider is non-contracted/out-of-network provider/facility, please explain why: ☐ New authorization request ☐ Extension of existing authorization. For extension of existing authorization, please submit Authorization Number:	
Who will supply the medication? ☐ Provider office ☐ Outpatient hospital/clinic ☐ Pharmacy not located within the servicing facility	Please select place of service by checking only one of the boxes: ☐ Provider office ☐ Outpatient hospital/clinic ☐ Other. Please specify:
Diagnosis codes:	Diagnosis:

Please attach all required documentation: recent clinical notes, copy of the prescription or physician order, relevant diagnostic labs.
All chemotherapy orders must indicate the number of cycles requested: Cycles

HCPCS codes	**Drug name** (if applicable)	**Dose** (if applicable)	**Frequency**	**Duration**

Note: If requesting more than 10 HCPCS codes please attach another form.