# HCPCS (HEALTHCARE COMMON PROCEDURE CODING SYSTEM) AUTHORIZATION FORM

(form effective 10/1/21)

Community **HealthChoices** | AmeriHealth *Caritas* Pennsylvania | *PERFORMRx*<sup>SM</sup> Next Generation Pharmacy Benefits

Fax to PerformRx<sup>SM</sup> at **1-855-851-4058**, or to speak to a representative call **1-888-674-8720**.

## 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:<br>Number of units:<br>Date of service (MM/DD/YYYY):      /      / |
|---|---|
| Directions: | |

| Medication name and strength requested: | J-code:<br>Number of units:<br>Date of service (MM/DD/YYYY):      /      / |
|---|---|
| Directions: | |

| Medication name and strength requested: | J-code:<br>Number of units:<br>Date of service (MM/DD/YYYY):      /      / |
|---|---|
| Directions: | |

| Medication name and strength requested: | J-code:<br>Number of units:<br>Date of service (MM/DD/YYYY):      /      / |
|---|---|
| Directions: | |

| Medication name and strength requested: | J-code:<br>Number of units:<br>Date of service (MM/DD/YYYY):      /      / |
|---|---|
| Directions: | |

| Medication name and strength requested: | J-code:<br>Number of units:<br>Date of service (MM/DD/YYYY):      /      / |
|---|---|
| Directions: | |

Anticipated length of therapy:      ☐ days      ☐ 3 months      ☐ 6 months

Diagnosis:

# HCPCS (HEALTHCARE COMMON PROCEDURE CODING SYSTEM) AUTHORIZATION FORM

| |
|---|
| 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):          /          / |
|---|---|

**Important payment notice**

Please note that reimbursement for all rendering network providers subject to the ordering/referring/prescribing (ORP) requirement for an approved authorization is determined by satisfying the mandatory requirement to have a valid Pennsylvania Medical Assistance (MA) Provider ID. Effective January 1, 2018, any claim submitted by rendering network providers that are subject to the ORP requirement will be denied when billed with the NPI of an ORP provider that is not enrolled in MA.

To check the MA enrollment status of the practitioner ordering, referring, or prescribing the service you are providing, visit the Department of Human Services (DHS) provider look-up portal at: **https://promise.dpw.state.pa.us/portal/Default.aspx?alias=promise.dpw.state.pa.us/portal/provider**.