

Today's date: \_\_\_\_\_

Intended date of injection: \_\_\_\_\_

## Prior Authorization Form

### Direct Ship General Drug Request – Medical Benefit Drugs Only

IF YOU ARE ORDERING BOTULINUM TOXINS (BOTOX, DYSPORT, MYOBLOC, XEOMIN), FASENRA, NUCALA, PROLIA/XGEVA, STELARA, VIVITROL, OR XOLAIR,

PLEASE DOWNLOAD THE APPROPRIATE DRUG-SPECIFIC FORM AT: [www.ibxtpa.com/directship](http://www.ibxtpa.com/directship).

USE THIS FORM TO REQUEST ALL OTHER DRUGS AVAILABLE THROUGH THE DIRECT SHIP DRUG PROGRAM.

THE COMPLETE LIST OF ALL DRUGS AVAILABLE THROUGH THIS PROGRAM CAN BE FOUND AT:  
[www.ibxtpa.com/pdfs/providers/pharmacy\\_information/direct\\_ship/direct-ship-injectables-list.pdf](http://www.ibxtpa.com/pdfs/providers/pharmacy_information/direct_ship/direct-ship-injectables-list.pdf).

REQUESTS FOR DRUGS THAT ARE NOT ON THE DIRECT SHIP DRUG LIST WILL NOT BE PROCESSED.

**ONLY COMPLETED REQUESTS WILL BE REVIEWED.**

Drug being requested: \_\_\_\_\_ Check one:  New start  Continued treatment

#### Patient information (please print)

#### Physician information (please print)

Patient name

Prescribing physician

Address

Office address

City, state, ZIP

City, state, ZIP

Patient telephone #

Office contact

Patient ID

Office telephone #

Date of birth

Weight

Height

Fax #

NPI

No delivery requested; physician will use office supply. Authorization only.

Delivery requested to the physician's office.

**\*\* A copy of the prescription must accompany the medication request for delivery.\*\***

1) Physician specialty (specify all): \_\_\_\_\_

2) Diagnosis for drug requested (must include ICD-10): \_\_\_\_\_

**3) Supporting member medical information/history**

Please add any member information that may be useful in the decision-making process.

Fax any additional information along with this form.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**4) Prescription information**

Quantity \_\_\_\_\_ refill x \_\_\_\_\_ month(s)

Instructions (include dose) \_\_\_\_\_ every \_\_\_\_\_ day(s)/ week(s)/ month(s)

Physician's signature \_\_\_\_\_

**Please fax this completed form to 215-761-9580**