Physician Request Form for Biological Medications
Fax to Pharmacy Services at **855-829-2872**, or call **855-251-0966**
to speak to a representative. ***Form must be completed for processing***.

AmeriHealth Caritas Delaware

Member Name: _____ Member ID#: _____

Address: _____ Apt # or Suite #: _____

City: _____State: _____ Zip Code: _____

Phone #: _____ Weight: _____lbs =_____Kg Birth Date: _____

Physician Name: _____ NPI #: _____

Address: _____ Apt # or Suite #: _____

City: _____ State: _____ Zip Code: _____

Contact Person: _____ Phone #: _____Fax #: _____

Physician Signature: _____ Date: _____Specialty: _____

Drug to be administered from (on):____ to ____ or was administered on: _____ to be replaced to physician's office.

Diagnosis: _____ ICD-10 Diagnosis Code: _____

Drug Name: _____ Dose: _____ Sig: _____

Pharmacy Information (Physician to identify the pharmacy that is to dispense the medication):

Pharmacy Name:_____ Pharmacy Phone #: _____ Pharmacy Fax #:_____

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Please identify the therapies attempted by completing the medication chart below indicating the dose, start date, end date and reasons for discontinuation (e.g. intolerance, hypersensitivity, treatment failure and/or any other medical reasons). Please attach any needed applicable documentation.

	Drug	Dose/Sig.	Start Date	End Date	Comments
☐	Topical Therapies: Please indicate their name(s):				
☐	Methotrexate (MTX)				
☐	Cyclosporine				
☐	Sulfasalazine				
☐	Phototherapy UVA/UVB therapy				
☐	Soriatane				
☐	Azathioprine				
☐	Oral Steroids (i.e. prednisone)				
☐	6-mercaptopurine				
☐	Mesalamine				
☐	NSAIDs				
☐	Leflunomide				
☐	Hydroxychloroquine				
☐	Other:				

Additional Comments: