Ascension
Personalized Care

APC precertification/PA fax:
512-831-5499

Medical specialty precertification/prior authorization request

Please submit all inquiries for prior authorization requests via the Online Provider Portal at https://bit.ly/AscensionProviderPortal. The Online Provider Portal is an all access entry into your authorization requests and determinations. For questions about a medical specialty drug prior authorization, please contact the team at 833-980-2352.

Ascension Personalized Care member ID: _____

Please indicate: ☐ Start of treatment - Start date: _____/_____/_____
☐ Continuation of treatment - Date of last treatment: _____/_____/_____

Priority:
☐Urgent
☐Routine

Precertification requested by: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:	DOB:	
Address:	City:	State:	ZIP:
APC ID:	Phone:	Email:	
Patient Current Weight: lbs or kgs	Patient Height: inches or cms	Allergies:	

B. PRESCRIBER INFORMATION

First Name:	Last Name: *(Check One)*: M.D. D.O. N.P. P.A.		
Address:	City:	State:	ZIP:
Phone:	Fax:		
NPI #: (REQUIRED)	Tax ID: (REQUIRED)		
Contact Name:	Contact Email:	Contact Phone:	

C. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-Administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
Administration Code(s) (CPT): _____
Address: _____
NPI (REQUIRED): _____
Tax ID (REQUIRED): _____

Place of Dispensing (Provider/Pharmacy):
☐ Physician's Office ☐ Retail Pharmacy
☐ Hospital Based Medication ☐ Clinic Medication
☐ Specialty Pharmacy ☐ Other: _____
Name: _____
Address: _____
Phone: _____
Fax: _____
NPI: _____

DIAGNOSIS INFORMATION

Diagnosis:	Staging:	ICD-10:

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E. CLINICAL INFORMATION – Provide medical necessity documentation for the requested medication including other medications tried (attach supporting documentation).

Clinical documentation to support medical necessity should be faxed back along with the completed form.

F ACKNOWLEDGEMENT

Request Completed By *(Signature Required)*:__Date:___/_____/_____

G. MEDICATION(S)/ONCOLOGY OR COMPLEX REGIMEN

1 Medication Name/Strength:		Dosing per Administration:	
Route of Administration:	Quantity:	Day Supply:	Expected Duration of Therapy:
HCPCs Code:		National Drug Code (NDC): *(if available)*	
2 Medication Name/Strength:		Dosing per Administration:	
Route of Administration:	Quantity:	Day Supply:	Expected Duration of Therapy:
HCPCs Code:		National Drug Code (NDC): *(if available)*	
3 Medication Name/Strength:		Dosing per Administration:	
Route of Administration:	Quantity:	Day Supply:	Expected Duration of Therapy:
HCPCs Code:		National Drug Code (NDC): *(if available)*	
4 Medication Name/Strength:		Dosing per Administration:	
Route of Administration:	Quantity:	Day Supply:	Expected Duration of Therapy:
HCPCs Code:		National Drug Code (NDC): *(if available)*	
5 Medication Name/Strength:		Dosing per Administration:	
Route of Administration:	Quantity:	Day Supply:	Expected Duration of Therapy:
HCPCs Code:		National Drug Code (NDC): *(if available)*	
6 Medication Name/Strength:		Dosing per Administration:	
Route of Administration:	Quantity:	Day Supply:	Expected Duration of Therapy:
HCPCs Code:		National Drug Code (NDC): *(if available)*	
7 Medication Name/Strength:		Dosing per Administration:	
Route of Administration:	Quantity:	Day Supply:	Expected Duration of Therapy: