



# Antimigraine Agents, Ergot Derivatives Prior Authorization of Benefits Form

**CONTAINS CONFIDENTIAL PATIENT INFORMATION**

**Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-474-3341.**

**1. Patient information**

**2. Physician information**

Patient name: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #: _____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

**3. Medication**

**4. Strength**

**5. Directions**

**6. Quantity per 30 days**

			Specify:
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**7. Diagnosis:**

**8. Approval criteria:** (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

Yes  No Does the client have a diagnosis of migraine in the last 365 days?  
 Yes  No Will the client have concurrent therapy with a contraindicated drug?  
 (Please see <https://paxpress.txpa.hidinc.com/ergot.pdf>)  
 Yes  No Does the client have a history of a contraindicated diagnosis in the last 365 days?  
 (Please see <https://paxpress.txpa.hidinc.com/ergot.pdf>)  
 For the *Texas Medicaid Preferred Drug List*, please refer to the Texas Medicaid Vendor Drug Program website at <https://www.txvendordrug.com/formulary/formulary-search>

**9. Physician signature**

_____	_____
Prescriber or authorized signature	Date

*Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider*

**[provider.wellpoint.com/tx/](https://provider.wellpoint.com/tx/)**

Medicaid services provided by Wellpoint Insurance Company to members in the Medicaid Rural Service Area and the STAR Kids program and Wellpoint Texas, Inc. to all other Wellpoint members in Texas.

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*certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.*

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