



Anxiolytics and Sedative Hypnotics Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION

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

1. Patient information

2. Physician information

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

3. Medication

4. Strength

5. Directions

6. Quantity per 30 days

| | | | |
|--|--|--|----------|
| | | | Specify: |
|--|--|--|----------|

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.)

Is this a request for initial therapy or is the patient currently taking the drug and is stable?

Yes No Initial therapy

Yes No Patient currently taking the drug and is stable

If yes, please indicate which agent: _____

Yes No Has the patient failed a 30-day treatment trial with at least one preferred agent(s) within the past 180 days?

If yes, please indicate which agent(s): _____

Yes No Is there a documented allergy or contraindication to preferred agents (at least one) in this class?

If yes, please indicate which agent(s): _____

Yes No Does the patient have a diagnosis of drug abuse or dependence in the last 730 days?

Yes No Does the patient have a diagnosis of an anxiety disorder, generalized anxiety disorder or panic disorder in the last 730 days?

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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.

- Yes No Does the patient have a diagnosis of epilepsy in the last 730 days?
- Yes No Does the patient have a history of an anticonvulsant agent in the last 45 days?
- Yes No Does the patient have a diagnosis of muscle disorder in the last 730 days?
- Yes No Does the patient have a diagnosis of chronic sleep disorder in the last 730 days?
- Yes No In the last 365 days?
- Yes No Does the patient have a diagnosis of insomnia in the last 180 days?
- Yes No In the last 730 days?
- Yes No Patient is being treated for stage-four advanced, metastatic cancer and associated conditions.

For the *Texas Medicaid Preferred Drug List*, please refer to the Texas Medicaid Vendor Drug Program website at <http://www.txvendordrug.com/formulary/formulary-search.asp>.

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 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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