



## *Plavix (Clopidogrel)* *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: _____          | 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**

|                      |  |  |          |
|----------------------|--|--|----------|
| Plavix (Clopidogrel) |  |  | Specify: |
|----------------------|--|--|----------|

**7. Diagnosis**

|  |
|--|
|  |
|--|

**8. Approval criteria:** Item (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.)

|                              |                             |   |
|------------------------------|-----------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Does patient have a diagnosis of cerebrovascular disease with recurrent ischemia, stroke, transient ischemic attack, acute coronary syndrome or peripheral artery disease in the last 730 days? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Does the client have one claim for an NSAID, warfarin and/or an SSRI/SNRI in the last 30 days?  |

**9. Physician signature**

|   |               |
|---|---------------|
| _____<br>Prescriber or authorized signature | _____<br>Date |
|---|---------------|

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

*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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