

Fabrazyme 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

Patient name: _____

Patient ID #: _____

Patient DOB: _____

Date of Rx: _____

Patient phone #: _____

Patient email address: _____

2. Physician information

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
Fabrazyme			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.)

Yes No Does the client have a diagnosis of Fabry disease in the last 730 days?
 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
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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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