

## Mayzent 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
Mayzent			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 multiple sclerosis in the last 730 days?

Yes  No Is the medication being prescribed concurrently with other disease modifying therapies for MS?

Yes  No Does the client have a CYP2C9\*3/\*3 genotype?

Yes  No Does the client have a diagnosis of myocardial infarction (MI), unstable angina, stroke, transient ischemic attack (TIA), decompensated heart failure requiring hospitalization or Class III/IV heart failure in the last 180 days?

Yes  No Does the client have a history of Mobitz type II second-degree, third-degree AV block or sick sinus syndrome (unless the client has a functioning pacemaker) in the last 180

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**

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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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