Wellpoint

Ponvory 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.

Patient information	**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: _____

Medication	**Strength**	**Directions**	**Quantity per 30 days**
Diagnosis			

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 Does the client have a diagnosis of moderate to severe hepatic impairment (Childs-Pugh class B and C) in the last 365 days?

☐ Yes ☐ No Is the medication being prescribed concurrently with other disease-modifying therapies for multiple sclerosis (MS)?

☐ Yes ☐ No Does the client have a diagnosis of myocardial infarction (MI), unstable angina, stroke, transientischemic 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, sick sinus syndrome or sino-atrial block (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 **https://www.txvendordrug.com/formulary/formulary-search**.
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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