

Recorlev Prior Authorization of Benefits Form

Texas | Medicaid

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

Recorlev			Specify:
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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.)

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the client have a diagnosis of endogenous Cushing's Syndrome for clients who have failed surgery or who are not candidates for surgery in the last 730 days?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is this a renewal request?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is the client greater than or equal to (≥) 18 years of age?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the client have a cirrhosis diagnosis, acute liver disease, or poorly controlled chronic liver disease, recurrent symptomatic cholelithiasis, or extensive metastatic liver disease in the last 365 days?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is the client currently pregnant?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the client have a prolonged QT syndrome, history of torsade de pointes, ventricular tachycardia, or ventricular fibrillation in the last 365 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 Has the client had therapy with drugs that cause QT prolongation, drugs that are sensitive substrates of CYP3A4 or CYP3A4 and P-gp, or strong CYP3A4 inhibitors or inducers in the last 90 days?

For the *Texas Medicaid Preferred Drug List*, please refer to the Texas Medicaid Vendor Drug Program website at txvendordrug.com/formulary/preferred-drugs

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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