Modified Formulations Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 844-512-9004.
Provider Help Desk: 800-454-3730

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**
_____	_____	_____	Specify: _____

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.)

Payment for a nonpreferred isomer, prodrug or metabolite will be considered when the following criteria are met: 1) previous trial with a preferred parent drug of the same chemical entity at a therapeutic dose that resulted in a partial response with a documented intolerance and 2) previous trial and therapy failure at a therapeutic dose with a preferred drug of a different chemical entity indicated to treat the submitted diagnosis if available. The required trials may be overridden when documented evidence is provided that the use of these preferred agent(s) would be medically contraindicated.

☐ Horizant (trial of gabapentin) ☐ Invega/Paliperidone ER (trial of risperidone) ☐ Trilipix (trial of Tricor)
☐ Xopenex HFA/levalbuterol tartrate (trial of albuterol HFA)
☐ Xopenex Nebs/levalbuterol nebs (trial of albuterol nebs)

Payment for a nonpreferred alternative delivery system will only be considered for cases in which the use of an alternative delivery system is medically necessary, and there is a previous trial and therapy failure with a preferred alternative delivery system as noted:

☐ Abilify Discmelt (Abilify soln) ☐ Alkindi (hydrocortisone tabs) ☐ Aricept ODT (Aricept tabs) ☐ Baqsimi (Glucagen)
☐ Binosto (alendronate tabs)
☐ Clozapine ODT/Fazaclo (clozapine tabs) ☐ Drizalma (duloxetine caps) ☐ Ezallor (rosuvastatin tabs)
☐ Lamotrigine ODT (lamotrigine chew tabs) ☐ Metoclopramide ODT (metoclopramide soln)

☐ Remeron SolTab (mirtazapine tabs) ☐ Risperdal M-Tab (risperidone soln) ☐ Sitavig (acyclovir oral susp)
☐ Spritam (levetiracetam soln) ☐ Sympazan (clobazam susp) ☐ Zyprexa Zydis (Zyprexa tabs)

Trial with parent drug product:
Drug name and dose:_____ Trial dates:_____
Failure Reason: _____

Trial with drug of a different chemical entity:
Drug name & dose: :_____ Trial dates: :_____
Failure Reason: _____

Medical necessity for alternative delivery system: _____
Failure reason of preferred alternative delivery system: _____
Medical or contraindication reason to override trial requirements: _____

Attach lab results and other documentation as necessary.

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.

Important note: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.