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Monoclonal Antibody Agents for Asthma
Prior Authorization of Benefits Form

Contains confidential patient information
Complete form in its entirety and fax to Prior Authorization of Benefits Center at **1-844-474-3341**.

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**
7. Diagnosis:			

8. Approval criteria: Check all boxes that apply. Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.

☐ Yes ☐ No	Does the patient have a diagnosis of severe asthma in the last 730 days?
☐ Yes ☐ No	Does the patient have a diagnosis of helminth infection in the last 180 days?
☐ Yes ☐ No	Does the patient have a diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA) in the past 730 days?
☐ Yes ☐ No	Has the patient had a trial of cyclophosphamide, azathioprine, methotrexate or leflunomide in the last 90 days, or is a trial of these medications contraindicated?
☐ Yes ☐ No	Does the client have a diagnosis of hypereosinophilic syndrome (HES) in the last 730 days?
☐ Yes ☐ No	Has the client had a trial of oral glucocorticoid therapy in the last 45 days, or is oral glucocorticoid therapy contraindicated?

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

9. Physician signature

Prescriber or authorized signature	Date

PA 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: You are not permitted to use or disclose Protected Health Information about individuals who you are not treating or are not enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.