Amerigroup

Medicaid

https://provider.amerigroup.com/TX

Humira and Biosimilar Agents
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**
Humira			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.)

□ Yes	□ No	The requested medication is being provided and billed at the physician's office?
□ Yes	□ No	Does the member have a diagnosis of rheumatoid arthritis (RA), ankylosing spondylitis (AS), psoriatic arthritis (PsA), ulcerative colitis (UC), uveitis (UV) and/or plaque psoriasis (Ps) in the last 730 days?
□ Yes	□ No	Does the member have a diagnosis of Crohn's disease in the last 730 days?
□ Yes	□ No	Does the member have a diagnosis of juvenile idiopathic arthritis (PJIA) in the last 730 days?
□ Yes	□ No	Does the member have a diagnosis of hidradenitis suppurativa (HS) in the last 730 days?
□ Yes	□ No	Does the member have a history of heart failure in the last 365 days?
□ Yes	□ No	Does the member have a history of demyelinating disease (multiple sclerosis, optic neuritis, and/or Guiallain-Barre syndrome) in the last 365 days?
□ Yes	□ No	Does the member have a history of hematologic abnormalities in the last 180 days?
□ Yes	□ No	Does the member have a serious active infection (including Hepatitis B virus and/or tuberculosis) 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

_____ _____

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.