Amerigroup

Medicaid

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Oralair 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.

1. Patient information

Patient name: _____
Patient ID #: _____
Patient DOB:_____
Date of Rx: _____
Patient phone #: _____
Patient email address:_____

2. Physician information

Prescribing physician: _____
Physician address: _____
Physician phone #: _____
Physician fax #: _____
Physician specialty: _____
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.)

□ Yes □ No Does the member have a diagnosis of allergic rhinitis in the last 730 days?
□ Yes □ No Has the client had hypersensitivity testing in the last five years?
□ Yes □ No Is there a documented allergy or contraindication to preferred agents (at least one) in this class?
□ Yes □ No Does the member have a history of severe, unstable, or controlled asthma OR a history of eosinophilic esophagitis in the last 365 days?
□ Yes □ No Patient has failed a 30-day treatment trial with at least 1 preferred agent(s) within the past 180 days.
□ Yes □ No Patient has a documented allergy or contraindication to preferred agents in this class.
□ Yes □ No Patient is being treated for stage-four advanced, metastatic cancer and associated conditions.
□ Yes □ No Does the client have 1 claim for auto-injectable epinephrine in the last 730 days or is the patient receiving auto-injectable epinephrine concurrently?
□ Yes □ No Has the client had therapy with an intranasal corticosteroid AND an intranasal antihistamine OR one combination intranasal corticosteroid and intranasal antihistamine product in the last 730 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**

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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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.