

Anxiolytics and Sedative Hypnotics 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. Pati	ient inf	ormation	2. Physician informat	tion			
Patien	t name:		Prescribing physician:				
Patien	t ID #: _		Physician address:				
Patien	t DOB:		Physician phone #:				
Date o	f Rx: _		Physician fax #:				
Patien	t phone	#:	Physician specialty:				
Patient email address:			Physician DEA:	Physician DEA:			
			Physician NPI #:	Physician NPI #:			
			Physician email addres	Physician email address:			
3. Med	dication	4. Strength	5. Directions	6. Quantity per 30 days			
				Specify:			
7. Dia	gnosis:			1			
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.)							
Is this a request for initial therapy or is the patient currently taking the drug and is stable?							
□ Yes		Initial therapy					
□ Yes	□ No	Patient currently taking the drug					
□ Vec	If yes, please indicate which agent: Yes □ No Has the patient failed a 30-day treatment trial with at least one preferred agent(s) within the past 180						
□ 1 CS		days?	reatment trial with at least one p	referred agent(s) within the past 100			
		If yes, please indicate which age	ent(s):				
□ Yes	□ No		r contraindication to preferred ag	gents (at least one) in this class?			
		If yes, please indicate which age	ent(s):				
□ Yes	□ No Does the patient have a diagnosis of drug abuse or dependence in the last 730 days?						
□ Yes	\square No	No In the last 730 days?					
□ Yes	\square No		is of an anxiety disorder, general	lized anxiety disorder or panic disorder			
		in the last 730 days?					
□ Yes							
□ Yes							
	☐ Yes ☐ No Does the patient have a diagnosis of muscle disorder in the last 730 days? ☐ Yes ☐ No Does the patient have a diagnosis of chronic sleep disorder in the last 730 days?						
□ Yes	□ No	Does the patient have a diagnos	is of chronic sleep disorder in the	e last 730 days?			

Amerigroup members in the Medicaid Rural Service Area and the STAR Kids program are served by Amerigroup Insurance Company; all other Amerigroup members in Texas are served by Amerigroup Texas, Inc.

\square Yes	□ No	In the last 365 days?			
\square Yes	\square No	Does the patient have a diagnosis of insomnia in the last 180 days?			
\square Yes	\square No	In the last 730 days?			
□ Yes	\square No	Patient is being treated for stage-four advanced, metastatic cancer and associated conditions.			
For the <i>Texas Medicaid Preferred Drug List</i> , please refer to the Texas Medicaid Vendor Drug Program website at http://www.txvendordrug.com/formulary/formulary-search.asp .					
9. Physician signature					
or a my statum or a statum or					

Prescriber or authorized signature	Date
Prior Authorization of Benefits is not the practice of medicine or the	he substitute for the independent medical judgment of a treating physician. Only a
treating physician can determine what medications are appropriate	te for a patient. Please refer to the applicable plan for the detailed information
regarding benefits, conditions, limitations, and exclusions. The suit	bmitting provider certifies that the information provided is true, accurate and
complete and the requested services are medically indicated and n	necessary to the health of the patient. Note: Payment is subject to member

eligibility. Authorization does not guarantee payment.

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