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GLP-1 Receptor Agonist 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	**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.)

☐ Yes ☐ No Does the patient have a diagnosis of type II diabetes in the last 365 days?
☐ Yes ☐ No Does the patient have a history of an oral antidiabetic agent for 14 days in the last 365 days?
☐ Yes ☐ No Does the patient have a history of the requested medication for 14 days in the last 365 days?
☐ Yes ☐ No Does the patient have a history of end-stage renal disease (ESRD), chronic kidney disease (stage IV and V), pancreatitis or gastroparesis in the last 730 days?
☐ Yes ☐ No Does the patient have a history of ESRD services (CPT® codes) in the last 730 days?
If yes, provide CPT code: _____
☐ Yes ☐ No Does the patient have a history of an HbA1c test in the last 180 days?
☐ Yes ☐ No Patient has failed a 30-day treatment trial with at least one 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.

For the *Texas Medicaid Preferred Drug List*, please refer to the Texas Medicaid Vendor Drug Program website at **http://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.