

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 **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.

<input type="checkbox"/>	<input type="checkbox"/>	Does the patient have a diagnosis of severe asthma in the last 730 days?
<input type="checkbox"/>	<input type="checkbox"/>	Does the patient have a diagnosis of helminth infection in the last 180 days?
<input type="checkbox"/>	<input type="checkbox"/>	Does the patient have a diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA) in the past 730 days?
<input type="checkbox"/>	<input type="checkbox"/>	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?
<input type="checkbox"/>	<input type="checkbox"/>	Does the client have a diagnosis of hypereosinophilic syndrome (HES) in the last 730 days?
<input type="checkbox"/>	<input type="checkbox"/>	Has the client had a trial of oral glucocorticoid therapy in the last 45 days, or is oral glucocorticoid therapy contraindicated?
<input type="checkbox"/>	<input type="checkbox"/>	Does the client have a diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA) in the last 730 days?
<input type="checkbox"/>	<input type="checkbox"/>	Will the client have concurrent therapy with intranasal corticosteroids?

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

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Prescriber or authorized signature	Date
<p>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.</p>	
<p>Note: Payment is subject to member eligibility. Authorization does not guarantee payment.</p>	
<p>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.</p>	