Amerigroup

Medicaid

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Phosphate Binders
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 client have a diagnosis of end-stage renal disease (ESRD) in the last 730 days?
□ Yes □ No Does the client have a diagnosis of hyperphosphatemia in the last 180 days?
□ Yes □ No Does the client have a diagnosis of iron deficiency anemia in the last 180 days?
□ Yes □ No Does the client have a diagnosis of chronic kidney disease (CKD) in the last 730 days?
□ Yes □ No Does the client have a history of dialysis in the last 180 days?
□ Yes □ No With severe vascular and/or soft tissue calcification in the last 180 days?
□ Yes □ No Does the client have a diagnosis of hypercalcemia (corrected calcium lab value > 10.2) or consecutive PTH lab values < 150 [manual] in the last 180 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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