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Medicaid

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Ponvory 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.

Patient information	**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: ____

Medication	**Strength**	**Directions**	**Quantity per 30 days**
			Specify:

Diagnosis:

Approval criteria: (Select 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 multiple sclerosis in the last 730 days?

□ Yes □ No Does the client have a diagnosis of moderate to severe hepatic impairment (Childs-Pugh class B and C) in the last 365 days?

□ Yes □ No Is the medication being prescribed concurrently with other disease-modifying therapies for multiple sclerosis (MS)?

□ Yes □ No Does the client have a diagnosis of myocardial infarction (MI), unstable angina, stroke, transientischemic attack (TIA), decompensated heart failure requiring hospitalization, or class III/IV heart failure in the last 180 days?

□ Yes □ No Does the client have a history of Mobitz type II second-degree, third-degree AV block, sick sinus syndrome or sino-atrial block (unless the client has a functioning pacemaker) 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**.

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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