

Topical Immunomodulators 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: _____ Patient ID #: _____ Patient DOB: _____ Date of Rx: _____ Patient phone #: _____ Patient email address: _____	Prescribing physician: _____ Physician address: _____ Physician phone #: _____ Physician fax #: _____ Physician specialty: _____ Physician DEA: _____ Physician NPI #: _____ Physician email address: _____
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3. Medication
4. Strength
5. Directions
6. Quantity per 30 days

			Specify:
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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.)

<input type="checkbox"/>	<input type="checkbox"/>	Does the patient have a diagnosis of atopic dermatitis in the last 730 days?
<input type="checkbox"/>	<input type="checkbox"/>	Does the patient have a diagnosis of HIV or immune system disorder in the last 730 days?
<input type="checkbox"/>	<input type="checkbox"/>	Does the patient have a diagnosis of a skin absorption disorder or a skin malignancy in the last 730 days?
<input type="checkbox"/>	<input type="checkbox"/>	Patient has failed a 30-day treatment trial with at least one preferred agent(s) within the past 180 days.
<input type="checkbox"/>	<input type="checkbox"/>	Patient has a documented allergy or contraindication to preferred agents in this class.
<input type="checkbox"/>	<input type="checkbox"/>	Patient is being treated for stage-four advanced, metastatic cancer and associated conditions.
<input type="checkbox"/>	<input type="checkbox"/>	Does the client have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days?
<input type="checkbox"/>	<input type="checkbox"/>	Will the client have concurrent therapy with therapeutic biologics, other JAK inhibitors or potent immunosuppressives?
<input type="checkbox"/>	<input type="checkbox"/>	Does the client have a diagnosis of atopic dermatitis or nonsegmental vitiligo in the last 730 days?
For the <i>Texas Medicaid Preferred Drug List</i> , please refer to the Texas Medicaid Vendor Drug Program website at https://www.txvendordrug.com/formulary/formulary-search		

<https://provider.amerigroup.com/TX>

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.

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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