Wellpoint

# *Arikayce 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** |
|---|---|---|---|
| Arikayce | _____ | _____ | Specify: _____ |

**7. Diagnosis**

**8. Approval criteria:** Item (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 mycobacterium avium complex (MAC) lung disease in the last 730 days?

For the Texas Medicaid Preferred Drug List, refer to the Texas Medicaid Vendor Drug Program website at **http://www.txvendordrug.com/formulary/formulary-search.asp**.

**9. Physician signature**





TXWP-CD-032638-23 | August 2023

| | |
|---|---|
| _____<br>Prescriber or authorized signature | _____<br>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.*<br>Note: Payment is subject to member eligibility. Authorization does not guarantee payment. | |
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