

Spingosine 1-Phosphate (S1P) Receptor Modulators Prior Authorization of Benefits Form

Texas | Medicaid

Contains confidential patient information.

Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 800-601-4829.

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.)

- Yes No Is the client greater than or equal to (\geq) 18 years of age?
- Yes No Does the client have a diagnosis of ulcerative colitis (UC) in the last 730 days?
- Yes No Does the client have a diagnosis of severe hepatic impairment in the last 365 days?
- Yes No Has the client had a 30-day trial with at least one conventional medication for the treatment of ulcerative colitis in the last 180 days, or has contraindications to conventional therapy?
- Yes No Does the client have a diagnosis of myocardial infarction (MI), unstable angina, stroke, transient ischemic 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 in the last 180 days?
- Yes No Does the client have a functioning pacemaker in the last 180 days?
- Yes No Does the client have a claim for a contraindicated medication in the last 30 days?
- Yes No Is the requested dose less than or equal to (\leq) 1 tablet daily?

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

9. Physician signature

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