Wellpoint

Amrix 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**
Amrix ER	☐ 15 mg capsule ☐ 30 mg capsule	_____	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	Patient has a diagnosis of acute myocardial infarction in the last 180 days.
☐ Yes ☐ No	Patient has a diagnosis of cardiac conditions (cardiac arrhythmias, heart block, congenital long QT syndrome, torsade de points), hyperthyroidism or heart failure in the last 730 days.
☐ Yes ☐ No	Patient has a history of monamine oxidase inhibitor (MAOI) in the last 14 days.
☐ Yes ☐ No	Patient has failed a 30-day treatment trial with at least 1 preferred agent(s) within the past 180 days.
☐ Yes ☐ No	Patient has a documented allergy or contraindication to preferred agents in this class.

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☐ Yes ☐ No Patient is being treated for stage-four advanced, metastatic cancer and associated conditions. For the *Texas Medicaid Preferred Drug List,* please refer to the Texas Medicaid Vendor Drug Program website at **https://www.txvendordrug.com/formulary/prior-authorization/preferred-drugs**.

9. Physician signature

_____	_____
Prescriber or authorized signature	Date
PA 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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