Cosentyx 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 **844-474-3341**.

1. Patient information	**2. Physician information**
Patient name: _____ Patient ID #: _____ Patient DOB: _____ Date of Rx: _____ Patient phone #:	Prescribing physician: _____ Physician address: _____ Physician phone #: _____ Physician fax #: _____ Physician specialty: _____ Physician DEA: _____ Physician NPI #: _____ Physician email address:
Patient email address:	

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
Cosentyx			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	Member has a diagnosis of ankylosing spondylitis, non-radiographic axial spondyloarthritis, psoriatic arthritis, hidradenitis suppurativa and/or moderate to severe plaque psoriasis in the last 730 days.
☐ Yes	☐ No	Member has a serious active infection (including hepatitis B virus and/or tuberculosis) in the last 180 days.
☐ Yes	☐ No	Member has failed a 30-day treatment trial with at least one preferred agent within the past 180 days.*
☐ Yes	☐ No	Member has a documented allergy or contraindication to preferred agents in this class.*
☐ Yes	☐ No	The requested medication is being provided and billed at the physician's office.
☐ Yes	☐ No	Patient is being treated for stage-four advanced, metastatic cancer and associated conditions.
☐ Yes	☐ No	Does the client have a diagnosis of enthesitis-related arthritis (ERA) in the last 730 days?

*__Please note__: The preferred agents include Enbrel and Humira.

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Medicaid services provided by Wellpoint Insurance Company to members in the Medicaid Rural Service Area and the STAR Kids program and Wellpoint Texas, Inc. to all other Wellpoint members in Texas.

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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**

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.