Wellpoint

Evrysdi 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**
Evrysdi			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 Is the client pregnant?

□ Yes □ No Does the client have a diagnosis of hepatic impairment?

Initial request:

□ Yes □ No Does the client have a diagnosis of spinal muscular atrophy (SMA) type 1, 2, or 3 in the last 730 days? (Supporting documentation must be provided along with baseline motor function tests)

Renewal request:

□ Yes □ No Has the client had a positive response to treatment, demonstrated by clinical improvement or no decline in function? (Supporting documentation must be provided comparing baseline functional scores to current scores)

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.
The document(s) accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.