Texas | Medicaid

Wellpoint

Naglazyme 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

Patient name: _____
Patient ID #: _____
Patient DOB: _____
Date of Rx: _____
Patient phone #: _____
Patient email address: _____

2. Physician information

Prescribing physician: _____
Physician address: _____
Physician phone #: _____
Physician fax #: _____
Physician specialty: _____
Physician DEA: _____
Physician NPI #: _____
Physician email address: _____

3. Medication	4. Strength	5. Directions	6. Quantity per 30 days
Naglazyme	_____	_____	Specify: _____

7. Diagnosis: _____

8. Approval criteria: CHECK ALL BOXES THAT APPLY
Note: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

☐ Yes ☐ No Patient has a diagnosis of mucopolysaccharidosis VI (MPS VI, Maroteaux-Lamy syndrome) in the past 730 days

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.

provider.wellpoint.com/tx/

Providers: You are required to return, destroy or further protect any PHI received on this document pertaining to members whom you are not treating. Providers are required to immediately destroy any such PHI or safeguard the PHI for as long as it is retained. In no event are you permitted to use or re-disclose such PHI.