CONTAINS CONFIDENTIAL PATIENT INFORMATION

Non-Preferred Medication Request

Prior Authorization of Benefits (PAB) Form 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
_____	_____	_____	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 Has the patient has had treatment failure with one preferred product?
If yes, please indicate which product: _____

☐ Yes ☐ No Does the patient have a contraindication to one preferred product?
If yes, please indicate which product: _____

☐ Yes ☐ No Has the patient had an allergic reaction to one preferred product?
If yes, please which product: _____

☐ Yes ☐ No Patient is being treated for stage-four advanced, metastatic cancer and associated conditions.

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.

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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.