Wellpoint

Olumiant 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: _____ Patient ID #: _____ Patient DOB: _____ Date of Rx: _____ Patient phone #: _____ Patient email address: _____	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**
Olumiant			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 Does the client have a diagnosis of rheumatoid arthritis in the last 730 days?
☐ Yes ☐ No Does the client have a diagnosis that indicates increased risk of GI perforation, thrombosis, or malignancy in the last 180 days?
☐ Yes ☐ No Does the client have a diagnosis of severe renal (eGFR < 30 mL/min/1.73m2) or severe hepatic impairment in the last 365 days?
☐ Yes ☐ No Patient has had a serious active infection (including hepatitis B virus and/or tuberculosis) in the last 180 days.
☐ Yes ☐ No Patient has failed a 30-day treatment trial with at least one preferred agent(s) within the past 180 days.
☐ Yes ☐ No Patient has a documented allergy or contraindication to preferred agents in this class.
☐ Yes ☐ No Patient is being treated for stage-four advanced, metastatic cancer, and associated conditions.
☐ Yes ☐ No Does the client have a diagnosis of alopecia areata in the last 730 days?

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.	
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