Texas | Medicaid

Wellpoint

# *Promethazine Age Edit 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: _____<br>Patient ID #: _____<br>Patient DOB: _____<br>Date of Rx: _____<br>Patient phone #: _____<br>Patient email address: _____ | Prescribing physician: _____<br>Physician address: _____<br>Physician phone #: _____<br>Physician fax #: _____<br>Physician specialty: _____<br>Physician DEA: _____<br>Physician NPI #: _____<br>Physician email address: _____ |

| **3. Medication** | **4. Strength** | **5. Directions** | **6. Quantity per 30 days** |
|---|---|---|---|
| ☐ Promethazine tablets<br>☐ Promethazine syrup<br>☐ Promethazine suppository<br>☐ Promethazine injectable | _____ | _____ | 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 is equal to or older than 2 years of age

**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.



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.