Wellpoint

Xopenex 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**
Xopenex	_____	_____	Specify: _____

7. Diagnosis _____

8. Approval criteria: Item (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 Has the patient failed a 30-day treatment trial with at least one preferred agent(s) within the past 180 days?
If yes, please indicate which agent(s): _____

☐ Yes ☐ No Does the patient have a diagnosis of cardiovascular disease (CVD) for 30 days in the past 180 days?

☐ Yes ☐ No Does the patient have intolerable side effects to at least one preferred agent(s)?

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	If yes, please indicate which agent(s): _____
☐ Yes ☐ No	Is there a documented allergy or contraindication to preferred agents (at least one) in this class?
	If yes, please indicate which agent(s): _____
☐ 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 is being treated for stage-four advanced, metastatic cancer and associated conditions.

For the *Texas Medicaid Preferred Drug List*, please refer to the Texas Medicaid Vendor Drug Program website at **https://www.txvendordrug.com/formulary/prior-authorization/preferred-drugs.**

9. Physician signature

_____	_____
Prescriber or authorized signature	Date

PA 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.