Wellpoint

Zeposia 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
Zeposia			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 Does the client have a diagnosis of multiple sclerosis in the last 730 days?
☐ Yes ☐ No Does the client have a diagnosis of severe hepatic impairment in the last 365 days?
☐ Yes ☐ No Is the medication being prescribed concurrently with other disease modifying therapies for MS?
☐ Yes ☐ No Does the client have a diagnosis of myocardial infarction (MI), unstable angina, stroke, transient ischemic attack (TIA), decompensated heart failure requiring hospitalization or Class III/IV heart failure in the last 180 days?
☐ Yes ☐ No Does the client have a history of Mobitz type II second-degree, third-degree AV block, sick sinus syndrome or sino-atrial block (unless the client has a functioning

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pacemaker) in the last 180 days?

☐ Yes ☐ No Does the client have a history of severe untreated sleep apnea in the last 365 days?

For the *Texas Medicaid Preferred Drug List*, please refer to the Texas Medicaid Vendor Drug Program website at **http://www.txvendordrug.com/formulary/formulary-search.asp**.

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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