Wellpoint

# *Sphingosine 1-Phosphate (S1P) Receptor Modulators Prior Authorization of Benefits Form*

Texas | Medicaid

**Contains confidential patient information.**
**Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 800-601-4829.**

| 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 |
| --- | --- | --- | --- |
| ______________ | ______________ | ______________ | Specify: ______________ |

**7. Diagnosis:** ______________________________________________


Medicaid coverage 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.
TXWP-CD-061450-24 | July 2024

**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 Is the client greater than or equal to (≥) 18 years of age?
☐ Yes ☐ No Does the client have a diagnosis of ulcerative colitis (UC) in the last 730 days?
☐ Yes ☐ No Does the client have a diagnosis of severe hepatic impairment in the last 365 days?
☐ Yes ☐ No Has the client had a 30-day trial with at least one conventional medication for the treatment of ulcerative colitis in the last 180 days, or has contraindications to conventional therapy?
☐ 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 in the last 180 days?
☐ Yes ☐ No Does the client have a functioning pacemaker in the last 180 days?
☐ Yes ☐ No Does the client have a claim for a contraindicated medication in the last 30 days?
☐ Yes ☐ No Is the requested dose less than or equal to (≤) 1 tablet daily?

For the Texas Medicaid Preferred Drug List, refer to the Texas Medicaid Vendor Drug Program website at: 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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