

Dipeptidyl Peptidase-4 (DPP-4) Inhibitors Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-474-3341.

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
Dipeptidyl Peptidase-4 (DPP-4) Inhibitors	_____	_____	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 patient have a diagnosis of moderate renal failure in the last 730 days?
☐ Yes ☐ No	Are the requested units less than or equal to one tablet per day?
☐ Yes ☐ No	Does the patient have a diagnosis of severe renal failure or ESRD in the last 730 days?
☐ Yes ☐ No	Does the patient have a diagnosis of type II diabetes in the past 730 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.

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>.

Amerigroup Appeal Forms For Providers

Thomas Griffiths



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