

PRIOR AUTHORIZATION REQUEST FORM EOC ID:

Depen Titratabs

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

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Patient Name:		Prescriber Name: Supervising Physician:	
Member/Subscriber Number:		Fax:	Phone:
Date of Birth:		Office Contact:	Flione.
Group Number:		NPI:	State Lic ID:
Address:		Address:	otate Elo ID.
City, State ZIP:		City, State ZIP:	
Primary Phone:		Specialty/facility name	(if applicable):
		operand, rading	(
Drug Name and Strength:			
Directions / SIG:			
Please attach any pertir		n for this patient that muestions and sign.	ay support approval. Please answer the
Q1. Please provide ICD o	code(s) for diagnosis		
Q2. What diagnosis is this	s drug being prescribed for?		
☐ Wilson's disease	☐ Other		
Q3. Is Depen being us	ed for acute copper toxicity or re	moval?	
☐ Yes	□No		
Q4. Is Depen being used	for maintenance therapy?		
☐ Yes	□ No		
Q5. If used for maintenan	nce, does the patient have failure	, contraindication, or ir	itolerance to zinc acetate?
Yes	□ No		
Q6. Additional Comments	S		
I			



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Prescriber Name:

Supervising Physician:

Prescriber Signature

Date

Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to the SWHP medical director at 1-888-316-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.

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