MOLINA HEALTHCARE

Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

Xenical (Medicaid)

This fax machine is located in a secure location as required by HIPAA Regulations. Complete / Review information, sign, and date. Fax signed forms to Molina Pharmacy Prior Authorization Department at **1-888-487-9251**. Please contact Molina Pharmacy Prior Authorization Department at **1-855-322-4080** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Xenical (Medicaid).

Drug Name (select from list of drugs shown)
Xenical 120mg Capsule

Patient Information	
Patient Name:	
Patient ID:	
Patient DOB:	

Prescribing Physician	
Physician Name:	
Physician Phone:	
Physician Fax:	
Physician Address:	
City, State, Zip:	

Diagnosis:	ICD Code:
Directions for administration:	

Please circle the appropriate answer for each question.

1. Has documentation of the patient's current lipid profile, height, and weight been provided? ☐ Y ☐ N
   If the answer to this question is yes, go to question 2.
   If the answer to this question is no, deny.

2. Is this request for continuation of therapy? ☐ Y ☐ N
   If the answer to this question is yes, go to question 3.
   If the answer to this question is no, go to question 4.

3. Has the prescriber documented that the patient demonstrated successes with therapy? ☐ Y ☐ N
   If the answer to this question is yes, go to question 10.
   If the answer to this question is no, denied.

4. Does the patient have a diagnosis of hyperlipidemia? ☐ Y ☐ N
   If the answer to this question is yes, go to question 5.
   If the answer to this question is no, deny.

5. Is the patient 21 years of age or older? ☐ Y ☐ N
   If the answer to this question is yes, go to question 6.
   If the answer to this question is no, deny.

6. Does the patient have total cholesterol that is greater than 200 mg/dL? ☐ Y ☐ N
If the answer to this question is yes, go to question 7.
If the answer to this question is no, deny.

7. Does the patient have a LDL greater than 130 mg/dL? ☐ Y ☐ N
If the answer to this question is yes, go to question 8.
If the answer to this question is no, deny.

8. Does the patient have a HDL less than 40 mg/dL? ☐ Y ☐ N
If the answer to this question is yes, go to question 9.
If the answer to this question is no, deny.

9. Is the requested dose greater than 360mg per day? ☐ Y ☐ N
If the answer to this question is yes, deny.
If the answer to this question is no, go to question 10.

10. Is this request for a non-preferred drug? ☐ Y ☐ N
The Texas Medicaid Preferred Drug List can be found at www.txvendordrug.com
If the answer to this question is yes, go to question 11.
If the answer to this question is no, approved for 6 months.

11. Has the patient had a treatment failure, contraindication, or allergy to a preferred drug within any subclass? ☐ Y ☐ N
If yes, please list which drug, dates tried, and describe treatment failure, contraindication, or allergy.

_____
If no, prior authorization is denied.

Comments:

I affirm that the information given on this form is true and accurate as of this date.

_____ _____
Prescriber (or Authorized) Signature Date