Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

Abstral / Lazanda / Subsys (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 Abstral / Lazanda / Subsys (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)			
ABSTRAL 100MCG SUBLINGUAL TABLETS	ABSTRAL 200MCG SUBLINGUAL TABLETS	ABSTRAL 300MCG SUBLINGUAL TABLETS	ABSTRAL 400MCG SUBLINGUAL TABLETS
ABSTRAL 600MCG SUBLINGUAL TABLETS	ABSTRAL 800MCG SUBLINGUAL TABLETS	LAZANDA 100MCG NASAL SPRAY	LAZANDA 300MCG NASAL SPRAY
LAZANDA 400MCG NASAL SPRAY	SUBSYS 1,200MCG SPRAY	SUBSYS 1,600MCG SPRAY	SUBSYS 100MCG SPRAY
SUBSYS 200MCG SPRAY	SUBSYS 400MCG SPRAY	SUBSYS 600MCG SPRAY	SUBSYS 800MCG SPRAY

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 include all relevant clinical notes, lab work, medication history and any other applicable documentation.**

Please circle the appropriate answer for each question.

1. Is the requested drug required per court order? (court order required) Y N
   If the answer to this question is yes, approved for 365 days.
   If the answer to this question is no, go to question 2.

2. Is the patient greater than or equal to 18 years of age? Y N
   If the answer to this question is yes, go to question 3.
   If the answer to this question is no, denied.

3. Does the patient have a diagnosis of malignancy in the last 730 days? Y N

If the answer to this question is yes, go to question 5.
If the answer to this question is no, go to question 4.

4. Does the patient have a history of antineoplastic therapy in the last 365 days? Y N
If the answer to this question is yes, go to question 5.
If the answer to this question is no, denied.

5. Does the patient have a claim for a long-acting opioid analgesic in the last 30 days? Y N
If the answer to this question is yes, go to question 6.
If the answer to this question is no, denied.

6. Does the patient have a claim for a monoamine oxidase inhibitor (MAOI) or CYP3A4 inhibitor in the last 30 days? Y N
If the answer to this question is yes, denied.
If the answer to this question is no, go to question 7.

7. Is the dose per day less than or equal to 3200mcg? Y N
If the answer to this question is yes, go to question 8.
If the answer to this question is no, denied.

8. Is the request for a non-preferred drug? Y N
If the answer to this question is yes, go to question 9.
If the answer to this question is no, approved for 365 days.

9. Has the patient failed a 6-day treatment trial with at least 1 preferred agent within the last 180 days? Y N
If the answer to this question is yes, approved for 365 days.
If the answer to this question is no, go to question 10.

10. Is there a documented allergy or contraindication to preferred agents in this class? Y N
If the answer to this question is yes, approved for 365 days.
If the answer to this question is no, go to question 11.

11. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions? Y N
If the answer to this question is yes, approved for 365 days.
If the answer to this question is no, denied.

Comments:

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

______________________________________ ____________________________
Prescriber (or Authorized) Signature Date