Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

Erythropoiesis-Stimulating Agents - Epogen, Procrit or Retacrit (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 Epogen, Procrit or Retacrit (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)		
EPOGEN 2,000 UNITS/ML VIAL	EPOGEN 3,000 UNITS/ML VIAL	EPOGEN 4,000 UNITS/ML VIAL
EPOGEN 10,000 UNITS/ML VIAL	EPOGEN 20,000 UNITS/2 ML VIAL	EPOGEN 20,000 UNITS/ML VIAL
PROCRIT 2,000 UNITS/ML VIAL	PROCRIT 3,000 UNITS/ML VIAL	PROCRIT 4,000 UNITS/ML VIAL
PROCRIT 10,000 UNITS/ML VIAL	PROCRIT 20,000 UNITS/ML VIAL	PROCRIT 40,000 UNITS/ML VIAL
RETACRIT 2,000 UNIT/ML VIAL	RETACRIT 3,000 UNIT/ML VIAL	RETACRIT 4,000 UNIT/ML VIAL
RETACRIT 10,000 UNIT/ML VIAL	RETACRIT 40,000 UNIT/ML VIAL	OTHER:_______________

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. Does the patient have a diagnosis of chronic renal failure in the last 730 days? Y N
   If the answer to this question is yes, go to question 8.

If the answer to this question is no, go to question 3.

3. Does the patient have a diagnosis of cancer in the last 730 days? Y N
   If the answer to this question is yes, go to question 4.
   If the answer to this question is no, go to question 6.

4. Does the patient have a history of an antineoplastic agent in the last 30 days? Y N
   If the answer to this question is yes, go to question 8.
   If the answer to this question is no, go to question 5.

5. Does the patient have a history of chemotherapy in the last 30 days? Y N
   If the answer to this question is yes, go to question 8.
   If the answer to this question is no, go to question 6.

6. Does the patient have a history of HIV in the last 730 days? Y N
   If the answer to this question is yes, go to question 7.
   If the answer to this question is no, denied.

7. Does the patient have a history of zidovudine in the last 90 days? Y N
   If the answer to this question is yes, go to question 8.
   If the answer to this question is no, denied.

8. Does the patient have a history of an erythropoiesis-stimulating agent (ESA) in the last 90 days? Y N
   If the answer to this question is yes, go to question 9.
   If the answer to this question is no, go to question 11.

9. Does the patient have a history of a complete blood count (CBC) in the last 90 days? Y N
   If the answer to this question is yes, go to question 10.
   If the answer to this question is no, denied.

10. Does the patient have a history of ferritin and iron binding capacity (IBC) tests in the last 180 days? Y N
    If the answer to this question is yes, go to question 11.
    If the answer to this question is no, denied.

11. Is the request for a non-preferred drug? Y N
    If the answer to this question is yes, go to question 12.
    If the answer to this question is no, approved for 365 days.

12. Has the patient failed a 30-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 13.

13. 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 14.

14. 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