Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

Growth Hormone - Zorbtive (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 Growth Hormone -Zorbtive (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)	
ZORBTIVE 8.8 MG 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 4 weeks.
   If the answer to this question is no, go to question 2.

2. Is the patient greater than or equal to 17 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 short bowel syndrome in the last 3 years? Y N
   If the answer to this question is yes, go to question 4.
   If the answer to this question is no, denied.

4. Does the patient have a diagnosis of active malignancy in the last 180 days? Y N
   If the answer to this question is yes, denied.
   If the answer to this question is no, go to question 5.

5. Does the patient have a history of chemotherapy/radiation (CPTs) in the last 180 days? Y N

If the answer to this question is yes, denied.
If the answer to this question is no, go to question 6.

6. Is this request for a non-preferred drug? Y N
If the answer to this question is yes, go to question 7.
If the answer to this question is no, approved for 4 weeks.

7. Has the patient been stable on 1 non-preferred agent for 30-days in the last 180 days? Y N
If the answer to this question is yes, approved for 4 weeks.
If the answer to this question is no, go to question 8.

8. 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 4 weeks.
If the answer to this question is no, go to question 9.

9. 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 4 weeks.
If the answer to this question is no, go to question 10.

10. 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 4 weeks.
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