Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

PDL - Proton Pump Inhibitors (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 PDL - Proton Pump Inhibitors (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)		
ESOMEPRAZOLE	LANSOPRAZOLE	OMEPRAZOLE OTC
OMEPRAZOLE / SODIUM BICARBONATE	RABEPRAZOLE	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. Is the request for Prevacid Solutabs and is the patient 10 years of age and under? 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 3.

3. Is this request for a non-preferred drug? Y N
   If the answer is yes, go to question 4.
   If the answer is no, approved for 365 days.

4. Has the patient failed a 30-day treatment trial with EACH preferred agent within the past 365 days? Y N

If the answer is yes, approved for 365 days.
If the answer is no, go to question 5.

5. Is there a documented allergy or contraindication to preferred agents in this class? Y N
If the answer is yes, approved for 365 days.
If the answer is no, go to question 6.

6. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions? Y N
If the answer is yes, approved for 365 days.
If the answer 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