Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

Growth Hormone - Serostim (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 -Serostim (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)		
SEROSTIM 4 MG VIAL	SEROSTIM 5 MG VIAL	SEROSTIM 6 MG VIAL

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 48 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 HIV 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 cachexia 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 claims for greater than or equal to 2 single ingredient antiretroviral agents or a Y N

claim for a combination ingredient antiretroviral agent in the last 90 days?
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 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 7.

7. 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 8.

8. Does the patient have a diagnosis of active proliferative or severe non-proliferative diabetic retinopathy in the last 365 days? Y N
If the answer to this question is yes, denied.
If the answer to this question is no, go to question 9.

9. Is this request for a non-preferred drug? Y N
If the answer to this question is yes, go to question 10.
If the answer to this question is no, approved for 48 weeks.

10. 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 48 weeks.
If the answer to this question is no, go to question 11.

11. 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 48 weeks.
If the answer to this question is no, go to question 12.

12. 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 48 weeks.
If the answer to this question is no, go to question 13.

13. 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 48 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