*Texas Standard Prior Authorization Form Addendum*

# Molina Healthcare of Texas
## Opioid Policy (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 Opioid Policy (Medicaid).

| Drug Name (select from list of drugs shown / provide drug information) |
|---|
| |

| 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 180 days.*
   *If the answer to this question is no, go to question 2.*

2. Does the patient have a diagnosis of sickle cell, cancer, palliative care or hospice care in the last 365 days? Y N
   *If the answer is yes, go to question 12.*
   *If the answer is no, go to question 3.*

3. Does the patient have a total of less than or equal to 7 days supply of opiates in the last 60 days? Y N
   *If the answer is yes, go to question 4.*
   *If the answer is no, go to question 11.*

4. Is the day supply of the requested medication greater than 10 days? Y N
   *If the answer is yes, denied*
   *If the answer is no, go to question 5.*

5. Is the request for a long-acting opioid agent? Y N

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

6. Is the incoming request greater than 90 morphine milligram equivalents (MME)? Y N
   *If the answer is yes, denied*
   *If the answer is no, go to question 7.*

7. Is this request for a non-preferred drug? Y N
   *If the answer is yes, go to question 8.*
   *If the answer is no, approved x 1 fill for incoming prescription.*

8. Has the patient failed a 6 day treatment trial with at least 1 preferred agent within the past 180 days? Y N
   *If the answer is yes, approved x 1 fill for incoming prescription..*
   *If the answer 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 is yes, approved x 1 fill for incoming prescription.*
   *If the answer 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 is yes, approved x 1 fill for incoming prescription.*
    *If the answer is no, denied.*

11. Does the patient's total opiate intake exceed 90 morphine milligram equivalents (MME) per day? Y N
    *If the answer is yes, denied.*
    *If the answer is no, go to question 12.*

12. Is this request for a non-preferred drug? Y N
    *If the answer is yes, go to question 13.*
    *If the answer is no, approved for 180 days.*

13. Has the patient failed a 6 day treatment trial with at least 1 preferred agent within the past 180 days? Y N
    *If the answer is yes, approved for 180 days.*
    *If the answer is no, go to question 14.*

14. Is there a documented allergy or contraindication to preferred agents in this class? Y N
    *If the answer is yes, approved for 180 days.*
    *If the answer is no, go to question 15.*

15. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions? Y N
    *If the answer is yes, approved for 180 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