



Texas Standard Prior Authorization Form Addendum

**Molina Healthcare of Texas
PDL 7 Day Treatment Trial (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 7 Day Treatment Trial (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)	
Anticoagulants:	Antifungals, Topical:
H.Pylori Treatment:	Otic AntiInfectives/Anesthetics:
Steroids, Topical:	

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.

- 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.*
- Is this request for a non-preferred drug? Y N
*If the answer to this question is yes, go to question 3.
 If the answer to this question is no, approved for 365 days.*
- Has the patient failed a 7-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 4.*

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| 4. Is there a documented allergy or contraindication to preferred agents in this class?
<i>If the answer to this question is yes, approved 365 days.</i>
<i>If the answer to this question is no, go to question 5.</i> | Y N |
| 5. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
<i>If the answer to this question is yes, approved 365 days.</i>
<i>If the answer to this question is no, denied.</i> | Y N |

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (or Authorized) Signature

Date