Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

150mg Aliskiren Containing Agents (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 150mg Aliskiren Containing Agents (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)	
TEKTURNA 150 MG TABLET	TEKTURNA HCT 150-12.5 MG TAB
TEKTURNA HCT 150-25 MG TABLET	ALISKIREN 150 MG TABLET

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 patient greater than or equal to 6 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 hypertension in the last 365 days? 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 pregnancy in the last 310 days? Y N
   If the answer to this question is yes, go to question 5.
   If the answer to this question is no, go to question 6.

5. Does the patient have a diagnosis to negate the pregnancy diagnosis in the last 310 days? Y N
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 renal artery stenosis 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 7.

7. Does the patient have a history of a cyclosporine or itraconazole agent in the last 30 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 diabetes mellitus in the last 730 days? Y N
If the answer to this question is yes, go to question 9.
If the answer to this question is no, go to question 10.

9. Does the patient have a history of an ACEI (Angiotensin Converting Enzyme Inhibitor) or ARB (Angiotensin Receptor Blocker) agent in the last 30 days? Y N
If the answer to this question is yes, denied.
If the answer to this question is no, go to question 10.

10. Are the requested units per day less than or equal to 2? Y N
If the answer to this question is yes, go to question 11.
If the answer to this question is no, denied.

11. Is this request for a non-preferred drug? Y N
If the answer to this question is yes, go to question 12.
If the answer to this question is no, approved for 365 days.

12. Has the patient failed a 14-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 13.

13. 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 365 days.
If the answer to this question is no, go to question 14.

14. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated onditions? Y N
If the answer to this question is yes, approved for 365 days.
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