Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

Anxiolytics-Alprazolam (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 Anxiolytics-Alprazolam (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)		
ALPRAZOLAM	ALPRAZOLAM ORAL CONC	ALPRAZOLAM ER
ALPRAZOLAM ODT	XANAX	XANAX XR

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 120 days.
   If the answer to this question is no, go to question 2.

2. Does the patient have a diagnosis of drug abuse in the last 730 days? Y N
   If the answer to this question is yes, denied.
   If the answer to this question is no, go to question 3.

3. Is the patient less than 18 years of age? Y N
   If the answer to this question is yes, denied.
   If the answer to this question is no, go to question 4.

4. Does the patient have a history of an alprazolam agent for greater than 120 days in the last 365 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 5.

5. Is this request for a non-preferred drug? Y N
If the answer to this question is yes, go to question 6.
If the answer to this question is no, approved for 120 day.

6. 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 120 days.
If the answer to this question is no, go to question 7.

7. 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 120 days.
If the answer to this question is no, go to question 8.

8. 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 120 days.
If the answer to this question is no, denied.

9. Is the incoming request for less than or equal to 1 days supply? Y N
If the answer to this question is yes, go to question 10.
If the answer to this question is no, go to question 15.

10. Is the incoming request for less than or equal to 5 units per day? 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 1 day.

12. 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 1 day.
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 1 day.
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 conditions? Y N
If the answer to this question is yes, approved for 1 day.
If the answer to this question is no, denied.

15. Has the patient had 1 claim for a selective serotonin reuptake inhibitor (SSRI) or a serotonin norepinephrine reuptake inhibitor (SNRI) in the last 180 days? Y N
If the answer to this question is yes, go to question 16.
If the answer to this question is no, denied.

16. Does the patient have a diagnosis of generalized anxiety disorder (GAD) or panic disorder in the last 730 days? Y N
If the answer to this question is yes, go to question 17.
If the answer to this question is no, denied.

17. Is this request for a non-preferred drug? Y N
If the answer to this question is yes, go to question 18.
If the answer to this question is no, approved for 120 days.

18. 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 120 days.
If the answer to this question is no, go to question 19.

19. 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 120 days.

If the answer to this question is no, go to question 20.

20. 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 120 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