Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

Diabetic Test Strips and Meters (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 Diabetic Test Strips and Meters (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 item 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. Does the patient have one claim for diabetic test strips more than 90 days ago? Y N
   If the answer to this question is yes, go to question 3.
   If the answer to this question is no, go to question 7.

3. Does the patient have a diagnosis of Type 1, 2 or pre-diabetes in the last 730 days? Y N
   If the answer to this question is yes, go to question 7.
   If the answer to this question is no, go to question 4.

4. Does the patient have a diagnosis of gestational diabetes in the last 365 days? Y N
   If the answer to this question is yes, go to question 7.
   If the answer to this question is no, go to question 5.

5. Does the patient have 1 claim for an agent used to treat diabetes in the last 730 days? Y N

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

6. Does the patient have one claim for a medication that can affect blood sugar levels (antipsychotic agents, oral glucocorticoid agents, etc.) or infers pregnancy in the last 365 days? Y N
If the answer to this question is yes, go to question 7.
If the answer to this question is no, denied.

7. Is the request for Truetest or True METRIX test strips? 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 8.

8. Is the patient on an insulin pump that communicates with the meter? Y N
Please specify brand: _____
If the answer to this question is yes, approved for 365 days.
If the answer to this question is no, go to question 9.

9. Is the patient using a talking meter? Y N
Please specify brand: _____
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