Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas
Compounded Medications (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 Compounded Medications (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)
Compounded Medications: _____

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 compounded medication 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. Is the requested compounded medication used for a Federal Drug Administration (FDA) approved indication or supported by an approved compendia (Thomson Micromedex, American Hospital Formulary Service, clinical pharmacology), physician supported guidelines or peer review literature? Y N
   If the answer to this question is yes, go to question 3.
   If the answer to this question is no, denied.

3. Is the compounded medication prepared for a patient with allergies to the commercially prepared medications? 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. Is the compounded oral medication used for members 12 years of age and younger or for Y N

members with difficulty swallowing?
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. Is the FDA-approved product not available or in short supply NOT due to the drug having been withdrawn or removed from the market for safety reasons? 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 a medical need for a different dosage form or strength than commercially available? Y N
If the answer to this question is yes, go to question 7.
If the answer to this question is no, denied.

7. Are one or more of the active ingredients non-preferred? Y N
If the answer to this question is yes, go to question 8.
If the answer to this question is no, approved for 180 days.

8. Has the patient failed a treatment trial with at least 1 preferred agent? 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 9.

9. 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 180 days.
If the answer to this question 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 to this question is yes, approved for 180 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