Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

Glatiramer Acetate Injection (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 Glatiramer Acetate Injection (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)		
COPAXONE 20MG/ML SYRINGE	COPAXONE 40MG/ML SYRINGE	GLATIRAMER 20MG/ML SYRINGE
GLATIRAMER 40MG/ML SYRINGE	GLATOPA 20MG/ML SYRINGE	GLATOPA 40MG/ML SYRINGE

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 18 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 multiple sclerosis (MS) in the last 730 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 request exceed the maximum recommended daily dose? Y N
   If the answer to this question is yes, denied.
   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 365 days.

6. 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 365 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 365 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 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