Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

Cough and Cold 2 to 4 Years Old (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 Cough and Cold 2 to 4 Years Old (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)		
ALA-HIST PE TABLET	APRODINE TABLET	BROTAPP LIQUID
CHEST CONGESTION RELIEF PE	CHEST CONGESTION RELIEF TABLET	CHL MUCINEX CHEST CONGEST LIQ
CHLD MUCINEX STUFFY NOSE-COLD	CHLO TUSS LIQUID	COUGH SYRUP 200MG/10 ML
DECONEX IR TABLET	DIMAPHEN ELIXIR	ED BRON GP LIQUID
ED-A-HIST PSE TABLET	ED CHLORPED D PEDIATRIC DROPS	GUAIFENESIN 100 MG/5 ML SYRUP
HISTEX-PE SYRUP	IOPHEN NR LIQUID	KID'S MUCINEX MINI-MELTS PACK
LODRANE D CAPSULE	LORTUSS LQ LIQUID	MAXIPHEN TABLET
MUCUS RELIEF 400 MG TABLET	MUCUS RELIEF SINUS TABLET	NOSE DROPS
ORGAN-I NR 200 MG TABLET	POLY-HIST PD LIQUID	PROMETHAZINE VC SYRUP
Q-TUSSIN 100 MG/5 ML SOLUTION	RESCON-GG LIQUID	RESPAIRE-30 CAPSULE
ROBAFEN 100 MG/5 ML SYRUP	RU-HIST D 10-4 MG TABLET	RYNEX PE LIQUID
RYNEX PSE LIQUID	SILTUSSIN SA 100 MG/5 ML SYR	STAHIST AD LIQUID
STAHIST AD TABLET	TUSSIN 100 MG/5 ML SYRUP	

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

2. Is the patient greater than or equal to 2 years of age and less than 4 year of age? 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 request for products containing acetaminophen or ibuprofen and is greater than or equal to 2 years of age or less than 6 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. Is the request for products containing opioids and the patient is 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 5.

5. Is this request for 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 30 days.

6. Has the patient failed a 3-day treatment trial with at least 1 preferred agent within the past 180 days? Y N
   If the answer to this question is yes, approved for 30 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 30 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 30 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