MOLINA HEALTHCARE

Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

Cough and Cold 2 to 6 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 6 Years Old (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)		
ALA-HIST DM LIQUID	ALAHIST CF TABLET	ALAHIST DM LIQUID
ALLFEN DM TABLET	AP-HIST DM LIQUID	BROMFED DM COUGH SYRUP
BROMPHENIR-PSEUDOEPHED-DM SYR	BROTAPP DM LIQUID	CHILD DELSYM COUGH 30 MG/5 ML
CHILD DELSYM COUGH+CHEST DM LQ	CHILD MUCINEX CONGEST-COUGH LQ	CHILD MUCINEX MULTI-SYMPTOM LQ
CHILDREN COLD & COUGH DM ELIXI	CHILDRENS DAYCLEAR ALLERGY COUGH	CHILDREN'S MUCINEX COUGH LIQ
COUGH DM 30 MG/5 ML SUSPENSION	DALLERGY 1-2.5 MG/ML DROPS	DALLERGY 1-5 MG TABLET
DECONEX DMX TABLET 17.5-400-10 MG TAB	DECONEX DMX TABLET 17.5-385-10 MG TAB	DELSYM 30 MG/5 ML SUSPENSION
DEXTROMETHORPHAN ER 30 MG/5 ML	DIMAPHEN DM ELIXIR	ED A-HIST DM TABLET
ED A-HIST LIQUID	ED-A-HIST 4 MG-10 MG TABLET	ED-A-HIST DM LIQUID
ENDACOF-DM LIQUID	EXTRA ACTION COUGH SYRUP	HISTEX-DM SYRUP
IOPHEN DM-NR LIQUID	KIDKARE COUGH & COLD LIQUID	LOHIST-D LIQUID
LOHIST-DM SYRUP	LORTUSS DM LIQUID	MAXIPHEN DM TABLET
M-END DMX LIQUID	M-HIST DM LIQUID	MUCINEX COUGH MINI-MELT PACK
MUCINEX SINUS-MAX NASAL SPRAY	NASAL DECONGESTANT 0.05% SPRAY	NASOPEN PE LIQUID
NINJACOF LIQUID	NOHIST-DM LIQUID	NOHIST-LQ LIQUID
PEDIATRIC COUGH-COLD LIQUID	PHENYLEPHRINE-PYRILAMINE 10-25	POLY-HIST DM LIQUID
POLY HIST FORTE 10.5-10 MG TAB	POLY HIST FORTE 7.5-10 MG TAB	POLYTUSSIN DM SYRUP
POLY-VENT DM TABLET	PROMETHAZINE-DM SYRUP	Q-TUSSIN DM SYRUP
RESCON-DM LIQUID	ROBAFEN CF LIQUID	ROBAFEN DM CGH-CHEST CONG SYRUP
ROBAFEN DM COUGH LIQUID	ROBAFEN-DM SYRUP	RYMED TABLET
RYNEX DM LIQUID	SILTUSSIN DM COUGH SYRUP	SILTUSSIN DM DAS LIQUID

SM TUSSIN DM LIQUID	SM TUSSIN DM SYRUP	SM NASAL SPRAY 0.05%
TUSSIN DM LIQUID	TUSSIN DM SYRUP	VANACOF DMX 18-396-10 MG/15 ML
VANACOF LIQUID	VANACOF-8 LIQUID	VANATAB AC CAPLET
VANATAB DM CAPLET	OTHER:_____	

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 6 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 the patient is 2 years of age and less than 6 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 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 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 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