Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

Cough and Cold 2 to 12 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 12 Years Old (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)		
DELSYM COUGH + CHEST CONGST DM LQ	GUAIFENESIN ER 1,200 MG TABLET	GUAIFENESIN/PSE ER 600-60 MG
MUCINEX D ER 1,200-120 MG TABLET	MUCINEX D ER 600-60 MG TABLET	MUCINEX DM ER 1,200-60 MG TAB
MUCINEX DM ER 600-30 MG TABLET	MUCINEX ER 1,200 MG TABLET	MUCINEX ER 600 MG TABLET
MUCINEX FAST-MAX CONGEST-COUGH	MUCINEX FAST-MAX DM MAX LIQUID	RESCON TABLET
ROBAFEN COUGH 15 MG LIQUIDGEL	SUDOGEST SINUS & ALLERGY TAB	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 12 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 3.

3. Is the request for products containing acetaminophen or ibuprofen and the patient is 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 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