Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

Cyclobenzaprine (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 Cyclobenzaprine (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)		
AMRIX ER 15 MG CAPSULE	AMRIX ER 30 MG CAPSULE	CYCLOBENZAPRINE 10 MG TABLET
CYCLOBENZAPRINE 5 MG TABLET	CYCLOBENZAPRINE 7.5 MG TABLET	FEXMID 7.5 MG TABLET

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 less than 15 years of age or greater than 65 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 day supply greater than 30 days for the current request and is there a cyclobenzaprine claim in the last 60 days? Y N
   If the answer to this is yes, go to question 4.
   If the answer to this is no, go to question 5.

4. Does the patient have a history of 2 cyclobenzaprine claims in the last 60 days with a combined days supply of greater than 30 days? Y N
   If the answer to this question is yes, denied.
   If the answer to this question is no, go to question 5.

5. Does the patient have a diagnosis of acute myocardial infarction in the last 180 days? Y N
   If the answer to this question is yes, denied.
   If the answer to this question is no, go to question 6.

6. Does the patient have a diagnosis of cardiac conditions (cardiac arrhythmias, heart block, congenital long QT syndrome, torsade de points), hyperthyroidism, or heart failure in the last 730 days? Y N
   If the answer to this question is yes, denied.
   If the answer to this question is no, go to question 7.

7. Does the patient have a claim for a monoamine oxidase inhibitor (MAOI) in the last 14 days? Y N
   If the answer to this question is yes, denied.
   If the answer to this question is no, go to question 8.

8. Is this request for a non-preferred drug? Y N
   If the answer to this question is yes, go to question 9.
   If the answer to this question is no, approved for 30 days.

9. Has the patient failed a 30-day treatment trial with at least 1 preferred agent within the last 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 10.

10. 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 11.

11. 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