Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

Cymbalta (Duloxetine) (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 Cymbalta (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)			
CYMBALTA 20MG CAPSULE	CYMBALTA 30MG CAPSULE	CYMBALTA 60MG CAPSULE	DULOXETINE HCL DR 20MG CAPSULE
DULOXETINE HCL DR 30MG CAPSULE	DULOXETINE HCL DR 40MG CAPSULE	DULOXETINE HCL DR 60MG CAPSULE	

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 7 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 generalized anxiety disorder (GAD) in the last 730 days? Y N
   If the answer to this question is yes, go to question 8.
   If the answer to this question is no, go to question 4.

4. 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 5.

If the answer to this question is no, denied.

5. Does the patient have a diagnosis of major depressive disorder (MDD) in the last 730 days? Y N
   If the answer to this question is yes, go to question 8.
   If the answer to this question is no, go to question 6.

6. Does the patient have a diagnosis of diabetic neuropathy, chronic musculoskeletal pain or fibromyalgia in the last 730 days? Y N
   If the answer to this question is yes, go to question 7.
   If the answer to this question is no, denied.

7. Is the requested dose less than or equal to 60mg/day? Y N
   If the answer to this question is yes, go to question 9.
   If the answer to this question is no, denied.

8. Is the requested dose less than or equal to 120mg/day? Y N
   If the answer to this question is yes, go to question 9.
   If the answer to this question is no, denied.

9. Has the patient had one claim for a monoamine oxidase inhibitor (MAOI) in the last 30 days? Y N
   If the answer to this question is yes, denied.
   If the answer to this question is no, go to question 10.

10. Has the patient had one claim for a potent CYP1A2 inhibitor in the last 90 days? Y N
    If the answer to this question is yes, denied.
    If the answer to this question is no, go to question 11.

11. Does the patient have a diagnosis of narrow angle glaucoma in the last 365 days? Y N
    If the answer to this question is yes, denied.
    If the answer to this question is no, go to question 12.

12. Is this request for a non-preferred drug? Y N
    If the answer to this question is yes, go to question 13.
    If the answer to this question is no, approved for 365 days.

13. Has the patient failed a 10-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 365 days.
    If the answer to this question is no, go to question 14.

14. 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 15.

15. 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