MOLINA HEALTHCARE

Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

Dipeptidyl Peptidase-4 (DPP-4) Inhibitors (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 Dipeptidyl Peptidase-4 (DPP-4) Inhibitors (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)		
ALOGLIPTIN TABLET	ALOGLIPTIN-METFORMIN	ALOGLIPTIN-PIOGLIT
GLYXAMBI	JANUVIA TABLET	JANUMET
JANUMET XR	JENTADUETO	JENTADUETO XR
KAZANO	KOMBIGLYZE XR	NESINA TABLET
ONGLYZA TABLET	OSENI	TRADJENTA TABLET
QTERN TABLET	STEGLUJAN TABLET	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 365 days.
   If the answer to this question is no, go to question 2.

2. Is the patient 18 years of age or older? 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 type 2 diabetes in the past 730 days? Y N

If the answer to this question is yes, go to question 4.
If the answer to this question is no, denied.

4. Is the request for one of the following drugs: A) Nesina (alogliptin) 6.25mg, B) Januvia 25mg, C) Onglyza 2.5mg, D) Tradjenta 5mg? Y N
If the answer to this question is yes, go to question 10.
If the answer to this question is no, go to question 5.

5. Is the request for one of the following drugs: A) Nesina (alogliptin) 12.5mg, B) Januvia 50mg? Y N
If the answer to this question is yes, go to question 6.
If the answer to this question is no, go to question 7.

6. Does the patient have the diagnosis of severe renal failure or ESRD in the past 730 days? Y N
If the answer to this question is yes, denied.
If the answer to this question is no, go to question 10.

7. Is the request for one of the following drugs: A) Nesina (alogliptin) 25mg, B) Januvia 100mg, C) Onglyza 5mg? 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 11.

8. Does the patient have the diagnosis of moderate renal failure in the past 730 days? Y N
If the answer to this question is yes, denied.
If the answer to this question is no, go to question 9.

9. Does the patient have a diagnosis of severe renal failure or ESRD 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 10.

10. Are the requested units less than or equal to 1 tablet per day? Y N
If the answer to this question is yes, go to question 12.
If the answer to this question is no, denied.

11. Does the patient have a diagnosis of severe renal failure or ESRD 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 12.

12. Is the 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 14-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