



## Texas Standard Prior Authorization Form Addendum

### Molina Healthcare of Texas Dextromethorphan Overutilization (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 Dextromethorphan Overutilization (Medicaid).

Dextromethorphan Containing Product (provide drug information)	

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 dose per day within the dosing limits for the patient's 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. Is this request for a non-preferred drug? Y N  
*If the answer to this question is yes, go to question 4.*  
*If the answer to this question is no, approved for 30 days*
4. Has the patient failed a 3-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 5.*
5. 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 6.*

6. 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.*

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Prescriber (or Authorized) Signature

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Date