Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

Duragesic (Transdermal Fentanyl) (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 Duragesic (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)		
DURAGESIC 25 MCG/HR PATCH	FENTANYL 100 MCG/HR PATCH	FENTANYL 12 MCG/HR PATCH
FENTANYL 25 MCG/HR PATCH	FENTANYL 37.5 MCG/HR PATCH	FENTANYL 50 MCG/HR PATCH
FENTANYL 62.5 MCG/HR PATCH	FENTANYL 75 MCG/HR PATCH	FENTANYL 87.5 MCG/HR PATCH

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. Does the patient have a history of cancer or fibrotic lung disease 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, go to question 3.

3. Does the patient have a history of an antineoplastic agent in the last 365 days? Y N
   If the answer to this question is yes, go to question 7.
   If the answer to this question is no, go to question 4.

4. Does the patient have less than or equal to 7 days opioid therapy in the last 30 days? Y N
   If the answer to this question is yes, go to question 5.
   If the answer to this question is no, go to question 7.

5. Does the patient have a diagnosis of chronic non-malignant pain (CNMP) in the last 365 days? Y N
   If the answer to this question is yes, go to question 7.
   If the answer to this question is no, go to question 6.

6. Does the patient have a history of an inferring CNMP non-opioid analgesic for less than or equal to 60 days out of 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 7.

7. Is the dose less than or equal to 25 mcg per hour? Y N
   If the answer to this question is yes, go to question 9.
   If the answer to this question is no, go to question 8.

8. Does the patient have less than or equal to 14 days of opioid therapy 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 9.

9. Is the dose less than or equal to 600 mcg per hour? Y N
   If the answer to this question is yes, go to question 10.
   If the answer to this question is no, denied.

10. Is this request for a non-preferred drug? Y N
    If the answer to this question is yes, go to question 11.
    If the answer to this question is no, approved for 365 days.

11. Has the patient failed a 6-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 12.

12. 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 13.

13. 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