Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

Gabapentin (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 Gabapentin (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)		
GABAPENTIN 600 MG TABLET	GABAPENTIN 800 MG TABLET	GABAPENTIN 100 MG CAPSULE
GABAPENTIN 300 MG CAPSULE	GABAPENTIN 400 MG CAPSULE	GABAPENTIN 250 MG/5 ML SOLN
NEURONTIN 100 MG CAPSULE	NEURONTIN 300 MG CAPSULE	NEURONTIN 400 MG CAPSULE
NEURONTIN 250 MG/5 ML SOLN	NEURONTIN 600 MG TABLET	NEURONTIN 800 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 365 days.
   If the answer to this question is no, go to question 2.

2. Is the patient less than 3 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 incoming request for a dose less than or equal to 1,400mg per day? 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 4.

4. Does the patient have a diagnosis of chronic kidney disease 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 5.

5. Does the patient have a dialysis CPT code 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 epilepsy/convulsions, neuropathic pain, migraine, restless leg syndrome or fibromyalgia 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 7.

7. Does the patient have a history of an inferred migraine agent in the last 90 days? Y N
   If the answer to this question is yes, go to question 8.
   If the answer to this question is no, denied.

8. Is the 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 365 days.

9. 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 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 365 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 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