Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas
HP Acthar Gel (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 HP Acthar Gel (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)
ACTHAR GEL 400 UNITS/5 ML VIAL

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 patient less than 2 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, go to question 4.

3. Does the patient have a diagnosis of infantile spasms 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, denied.

4. Does the patient have a diagnosis of multiple sclerosis in the last 730 days? Y N
   If the answer to this question is yes, go to question 5.
   If the answer to this question is no, denied.

5. 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 6.
If the answer to this question is no, denied.

6. Does the patient have 1 claim for a corticosteroid in the last 60 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 documented contraindication or intolerance to corticosteroid therapy? Y N
If the answer to this question is yes, go to question 8.
If the answer to this question is no, denied.

8. Does the patient have a diagnosis of scleroderma, osteoporosis, systemic fungal infection, ocular herpes simplex, peptic ulcer and/or heart failure 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 9.

9. Is this request for a non-preferred drug? Y N
If the answer to this question is yes, go to question 10.
If the answer to this question is no, approved for 30 days.

10. Has the patient failed a treatment trial with at least 1 preferred agent? 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 11.

11. Is there a documented allergy or contraindication to preferred agents in this class? Y N
If the answer to this question is yes, go to approved for 30 days.
If the answer to this question is no, go to question 12.

12. 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.

_____ _____
Prescriber (or Authorized) Signature Date