Prior Authorization Form

Molina Healthcare of Texas

Mobic (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 Mobic (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)	
Mobic 7.5mg Tablet	Mobic 15mg tablet
Meloxicam 7.5mg Tablet	Meloxicam 15mg Tablet
Meloxicam 7.5mg/5mL Suspension	

Patient Information	
Patient Name:	
Patient ID:	
Patient Group No.:	
Patient DOB:	

Prescribing Physician	
Physician Name:	
Physician Phone:	
Physician Fax:	
Physician Address:	
City, State, Zip:	

Diagnosis:	ICD Code:

Please circle the appropriate answer for each question.

1. Is the patient less than (<) 18 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 2.

2. Is the patient greater than or equal to ( ) 60 years of age? Y N
   If the answer to this question is yes, go to question 11.
   If the answer to this question is no, go to question 3.

3. Does the patient have a diagnosis of Peptic Ulcer Disease (PUD) or gastrointestinal (GI) bleed in the last 730 days? Y N
   If the answer to this question is yes, go to question 11.
   If the answer to this question is no, go to question 4.

4. Does the patient have a history of warfarin therapy for 30 days in the last 45 days? Y N
   If the answer to this question is yes, go to question 11.
   If the answer to this question is no, go to question 5.

5. Has the patient had corticosteroid therapy for greater than or equal to ( ) 35 days in the last 90 days? Y N
If the answer to this question is yes, go to question 11.
If the answer to this question is no, go to question 6.

6. Has the patient taken high dose Non-Steroidal Anti-Inflammatory Drug (NSAID) therapy for 30 days in the last 45 days? Y N
If the answer to this question is yes, go to question 11.
If the answer to this question is no, go to question 7.

7. Does the patient have a diagnosis of Rheumatoid Arthritis (RA), Juvenile Rheumatoid Arthritis (JRA), or Osteoarthritis (OA) in the last 730 days? Y N
If the answer to this question is yes, go to question 11.
If the answer to this question is no, go to question 8.

8. Does the patient have a history of a disease-modifying antirheumatic drug (DMARD) agent for 30 days in the last 60 days? Y N
If the answer to this question is yes, go to question 11.
If the answer to this question is no, go to question 9.

9. Does the patient have a history of 2 or more NSAID agents for 30 days in the last 180 days? Y N
If the answer to this question is yes, go to question 11.
If the answer to this question is no, go to question 10.

10. Does the patient have a diagnosis of Familial Adenomatous Polyposis (FAP) or ankylosing spondylitis 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 11.

11. Is this request for a non-preferred drug? Y N
The Texas Medicaid Preferred Drug List can be found at txvendordrug.com
If the answer to this question is yes, go to question 12.
If the answer to this question is no, approved for 365 days.

12. Has the patient had a treatment failure with a preferred drug within any subclass? Y N
If yes, please list which drug, dates tried, and describe treatment failure. ________________________
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If the answer to this question is no, go to question 13.

13. Does the patient have a contraindication to any preferred drugs? Y N
If yes, please list which drug, dates tried, and describe contraindication. ________________________
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If the answer to this question is no, go to question 14.

14. Has the patient had an allergic reaction to any preferred drugs? Y N
If yes, please list which drug, dates tried, and describe allergic reaction. ________________________
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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