Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas
Opiate 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 Opiate Overutilization (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)
Opiate Overutilization

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 diagnosis of sickle cell, cancer, palliative care or hospice care in the last 730 days? Y N
   If the answer is yes, go to question 3.
   If the answer is no, go to question 4.

3. Does the patient have one of the following: A) greater than or equal to 3 different opiate medications in the last 60 days, B) greater than or equal to 4 opiate claims in the last 60 days, C) greater than or equal to a 90 day supply of opiate medications in the last 60 days? Y N
   If the answer is yes, denied.
   If the answer is no, go to question 5.

4. Does the patient have one of the following: A) greater than or equal to 2 different opiate medications in the last 60 days, B) greater than or equal to 3 opiate claims in the last 60 days, C) greater than or equal Y N

to a 90 day supply of opiate medications in the last 60 days?
If the answer is yes, denied.
If the answer is no, go to question 5.

5. Does the patient have greater than or equal to 3 prescribers of opiates in the last 60 days? Y N
If the answer is yes, denied.
If the answer is no, go to question 6.

6. Does the patient have greater than or equal to 3 opiate dispensing pharmacies in the last 60 days? Y N
If the answer is yes, denied.
If the answer is no, go to question 7.

7. Is this request for a non-preferred drug? Y N
If the answer is yes, go to question 8.
If the answer is no, approved for 365 days.

8. Has the patient failed a 6-day treatment trial with at least 1 preferred agent within the past 180 days? Y N
If the answer is yes, approved for 365 days.
If the answer is no, go to question 9.

9. Is there a documented allergy or contraindication to preferred agents in this class? Y N
If the answer is yes, approved for 365 days.
If the answer is no, go to question 10.

10. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions? Y N
If the answer is yes, approved for 365 days.
If the answer 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