Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas
Oral/Inhaled PH Agents (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 Oral/Inhaled PH Agents (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)		
ADEMPAS TABLET	LETAIRIS TABLET (INCLUDES GEN)	OPSUMIT TABLET
ORENITRAM ER TABLET	TRACLEER TABLET (INCLUDES GEN)	TRACLEER TABLET FOR SUSP
TYVASO SOLUTION	TYVASO INHALATION STARTER KIT	TYVASO INHALATION REFILL KIT
UPTRAVI TABLET	UPTRAVI TITRATION PACK	VENTAVIS SOLUTION
	OTHER:_____	

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 pulmonary arterial hypertension (PAH) 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, go to question 3.

3. Is the requested medication for Adempas (riociguat)? Y N
If the answer to this question is yes, go to question 4.
If the answer to this question is no, denied.

4. Does the patient have a diagnosis of chronic thromboembolic pulmonary hypertension (CTEPH) in the last 730 days? Y N
If the answer to this question is yes, go to question 6.
If the answer to this question is no, denied.

5. Has the diagnosis been confirmed by or does the patient have a contraindication to right heart catheterization? Y N
If the answer to this question is yes, go to question 7.
If the answer to this question is no, denied.

6. Has the diagnosis been confirmed by or does the patient have a contraindication to pulmonary angiogram? Y N
If the answer to this question is yes, go to question 7.
If the answer to this question is no, denied.

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

8. Has the patient failed a 14-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 9.

9. 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 10.

10. 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