Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

Oxycodone Extended Release High Dose (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 Oxycodone Extended Release High Dose (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)	
OXYCODONE HCL ER 60 MG TABLET	OXYCODONE HCL ER 80 MG TABLET
OXYCONTIN 60 MG TABLET	OXYCONTIN 80 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. Does the patient have a diagnosis of malignant cancer in the past 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. Does the patient have a history of an antineoplastic agent in the last 365 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 4.

4. Does the patient have a diagnosis of Chronic Non-Malignant Pain (CNMP) in the past 365 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. Does the patient have less than 14 days of opioid therapy in the last 30 days? 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 10.

6. Has the patient tried other pain management therapies? Y N
   If the answer to this question is yes, go to question 7.
   If the answer to this question is no, denied.

7. Has the prescriber provided medical justification for the use of a higher strength? 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 pain management agreement with the prescriber? Y N
   If the answer to this question is yes, go to question 9.
   If the answer to this question is no, denied.

9. Is the requested quantity less than or equal to 3 tablets per day? Y N
   If the answer to this question is yes, go to question 10.
   If the answer to this question is no, denied.

10. Is the request for a non-preferred drug? Y N
    If the answer to this question is yes, go to question 11.
    If the answer to this question is no, approved for 365 days.

11. Has the patient failed a 6-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 12.

12. 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 13.

13. 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