Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas
PDL – Macrolides (Oral) (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 PDL – Macrolides (Oral) (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)			
AZITHROMYCIN	CLARITHROMYCIN TABLETS	CLARITHROMYCIN SUSPENSION	CLARITHROMYCIN ER
ERYTHROMYCIN BASE	ERYTHROMYCIN BASE FILMTAB	ERYTHROMYCIN ETHYLSUCCINATE SUSPENSION	E.E.S. (erythromycin)
ERYPED (erythromycin)	ERY-TAB (erythromycin)	ERYTHROCIN (erythromycin)	ZITHROMAX (azithromycin)

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 this request for a non-preferred drug? Y N
   If the answer is yes, go to question 3.
   If the answer is no, approved for 30 days.

3. Does the patient have a diagnosis of gastroparesis or gastroesophageal reflux disease (GERD) associated Y N

with gastrostomy in the last 365 days (See Table A)?
If the answer is yes, approved for 90 days.
If the answer is no, go to question 4.

4. Has the patient failed a 7-day treatment trial with at least 1 preferred agent within the last 180 days? Y N
[Note: Exception may apply when a preferred drug requires less than a 7-day treatment trial.]
If the answer is yes, approved for 30 days.
If the answer is no, go to question 5.

5. Is there a documented allergy or contraindication to preferred agents in this class? Y N
If the answer is yes, approved for 30 days.
If the answer is no, go to question 6.

6. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions? Y N
If the answer is yes, approved for 30 days.
If the answer is no, denied.

Table A: (Diagnosis of gastroparesis or GERD associated with gastrostomy)

ICD-10 Code	Description
E0843	DIABETES MELLITUS DUE TO UNDERLYING CONDITION WITH DIABETIC AUTONOMIC (POLY)NEUROPATHY
E1043	TYPE 1 DIABETES MELLITUS WITH DIABETIC AUTONOMIC (POLY)NEUROPATHY
E1143	TYPE 2 DIABETES MELLITUS WITH DIABETIC AUTONOMIC (POLY)NEUROPATHY
E1343	OTHER SPECIFIED DIABETES MELLITUS WITH DIABETIC AUTONOMIC (POLY)NEUROPATHY
K3184	GASTROPARESIS
K9420	GASTROSTOMY COMPLICATION, UNSPECIFIED
K9429	OTHER COMPLICATIONS OF GASTROSTOMY

Comments:

I affirm that the information given on this form is true and accurate as of this date.

_____ _____
Prescriber (or Authorized) Signature Date