Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

Promethazine/Promethazine Containing Products (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 Promethazine/Promethazine Containing Products (Medicaid).

Drug Name (select from list of drugs shown)		
Phenadoz 25 mg supp	Phenergan 25 mg/ml vial	Promethazine 12.5 mg tablet
Promethazine 12.5mg supp	Promethazine 25 mg supp	Promethazine 25 mg tablet
Promethazine 25 mg/ml ampul	Promethazine 25 mg/ml vial	Promethazine 50 mg supp
Promethazine 50 mg tablet	Promethazine 50 mg/ml ampul	Promethazine 50 mg/ml vial
Promethazine 6.25 mg/5 ml syr	Promethazine vc syrup	Promethazine vc-codeine syrup
Promethazine-codeine syrup	Promethazine-DM syrup	Promethegan 12.5 mg supp
Promethegan 25 mg supp	Promethegan 50 mg supp	Others, Please specify

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 greater than or equal to ($\geq$) 2 years of age? Y N
   If the answer to this question is yes, go to question 2.
   If the answer to this question is no, denied.

2. Is the request for products containing codeine? Y N
   If the answer to this question is yes, go to question 3.
   If the answer to this question is no, go to question 4.

3. Is the patient greater than 12 years of age? Y N

If the answer to this question is yes, go to question 4.
If the answer to this question is no, denied.

4. Is the request for non-preferred agents? Y N

If the answer to this question is yes, go to question 5.
If the answer to this question is no, approve for 365 days.

5. Has the patient failed a 3-day treatment trial with at least 1 preferred product within the past 180 days? Y N

If the answer to this question is yes, approve for 365 days.
If the answer to this question is no, go to question 6.

6. Is there a documented allergy or contraindication to preferred agents in this class? Y N

If the answer to this question is yes, approve 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 ______________________