Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

Phosphate Binders (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 Phosphate Binders (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)		
AURYXIA 210 MG TABLET	CALCIUM ACETATE 667 MG CAPSULE	CALCIUM ACETATE 667 MG TABLET
ELIPHOS 667 MG TABLET	FOSRENOL 500 MG TABLET CHEW	FOSRENOL 750 MG POWDER PACKET
FOSRENOL 750 MG TABLET CHEW	FOSRENOL 1,000 MG POWDER PACKET	FOSRENOL 1,000 MG TABLET CHEW
LANTHANUM CARB 500 MG TAB CHEW	LANTHANUM CARB 750 MG TAB CHEW	LANTHANUM CARB 1,000 MG TB CHW
PHOSLYRA 667 MG/5 ML SOLUTION	VELPHORO 500 MG CHEWABLE TAB	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. Is the patient 18 years of age or older? Y N
   If the answer to this question is yes, go to question 3.

If the answer to this question is no, denied.

3. Is the request for a non-preferred drug? Y N
   If the answer to this question is yes, go to question 4.
   If the answer to this question is no, approved for 365 days.

4. Does the patient have a diagnosis of End Stage Renal Disease (ESRD) in the past 180 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 14.

5. Does the patient have a diagnosis of hyperphosphatemia in the past 180 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 14.

6. Has the patient failed a 30-day treatment trial with at least 1 preferred agent within the last 180 days? Y N
   If the answer to this question is yes, go to question 8.
   If the answer to this question is no, go to question 7.

7. Is there a documented allergy or contraindication to preferred agents in this class? Y N
   If the answer to this question is yes, go to question 8.
   If the answer to this question is no, go to question 14.

8. Does the patient have a diagnosis of hypercalcemia in 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. Does the patient have a history of a corrected calcium lab value greater than 10.2 in the past 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 10.

10. Does the patient have a history of consecutive PTH lab values less than 150 in the past 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 11.

11. Does the patient have a diagnosis of dialysis in the past 180 days? Y N
    If the answer to this question is yes, go to question 12.
    If the answer to this question is no, go to question 14.

12. Does the patient have a history of Current Procedural Terminology (CPT) codes for dialysis in the past 180 days? Y N
    If the answer to this question is yes, go to question 13.
    If the answer to this question is no, go to question 14.

13. Does the patient have a history of vascular or soft tissue calcification in the past 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 14.

14. 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