Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas
Proton Pump Inhibitors (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 Proton Pump Inhibitors (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)		
ACIPHEX TABLET	ACIPHEX SPRINKLE CAP	DEXILANT CAPSULE
NEXIUM PACKET	NEXIUM CAPSULE	PREVACID SOLUTAB
PREVACID CAPSULE	PROTONIX SUSPENSION	PROTONIX TABLET
PROTONIX IV VIAL	ZEGERID CAPSULE	ZEGERID PACKET

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 90 days.
   If the answer to this question is no, go to question 2.

2. Does the patient have a diagnosis of Zollinger-Ellison syndrome or Barrett's esophagus in the last 730 days? Y N
   If the answer to this question is yes, go to question 4.
   If the answer to this question is no, go to question 3.

3. Does the patient have greater than or equal to 120 days therapy in the last 365 days? Y N
   If the answer to this question is yes, denied.

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

4. Is the request for Prevacid Solutabs and is the patient 10 years of age and under? Y N
   If the answer to this question is yes, approved for 90 days
   If the answer to this question is no, go to question 5.

5. Is the request for a non-preferred drug? Y N
   If the answer to this question is yes, go to question 6.
   If the answer to this question is no, approved for 90 days.

6. Has the patient failed a 30-day treatment trial with EACH preferred agent within the lastt 180 days? Y N
   If the answer to this question is yes, approved for 90 days.
   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, approved for 90 days.
   If the answer to this question is no, go to question 8.

8. 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 90 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