MOLINA HEALTHCARE

Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

Topical Acne Agents (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 Topical Acne Agents (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)		
ACNE MEDICATION GEL	ACNE MEDICATION LOTION	ACZONE GEL PUMP
AZELAIC ACID GEL	AZELEX CREAM	BENSAL HP OINTMENT
BENZACLIN GEL	BENZACLIN GEL PUMP	BENZEFOAM EMOLLIENT FOAM
BENZOYL PEROXIDE GEL	BENZOYL PEROXIDE WASH	CLEOCIN T GEL
CLEOCIN T LOTION	CLEOCIN T PLEDGETS	CLINDAMYCIN PH FOAM
CLINDAMYCIN PH GEL	CLINDAMYCIN PH LOTION	CLINDAMYCIN PH PLEDGET
CLINDAMYCIN PH SOLUTION	CLINDA-BENZOYL PEROX PUMP	CLINDAMYCIN-BENZOYL PEROXIDE GEL
DUAC GEL	ERY PADS	ERYGEL GEL
ERYTHROMYCIN GEL	ERYTHROMYCIN PLEDGETS	ERYTHROMYCIN SOLUTION
ERYTHROMYCIN-BENZOYL GEL	EVOCLIN FOAM	FINACEA GEL
METROCREAM CREAM	METROGEL TOPICAL GEL	METROGEL TOPICAL PUMP
METROLOTION TOPICAL	METRONIDAZOLE CREAM	METRONIDAZOLE LOTION
METRONIDAZOLE TOPICAL GEL	SODIUM SULFACETAMIDE LOTN	SULFACETAMIDE SOD TOP SUSP

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 rosacea or actinic keratosis 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 1 claim for a 30 day trial of a topical retinoid product 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, denied.

4. Is this request for a non-preferred drug? Y N
   If the answer to this question is yes, go to question 5.
   If the answer to this question is no, approved for 365 days.

5. 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, approved 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, approved for 365 days.
   If the answer to this question is no, go to question 7.

7. 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