Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

Actiq (Mediciad)

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 Actiq (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)	
ACTIQ LOZENGE	FENTANYL CITRATE OTFC

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 less than 16 years of age? Y N
   If the answer to this question is yes, denied.
   If the answer to this question is no, go to question 3.

3. Does the patient have a diagnosis of cancer or fibrotic lung disease in the last 730 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 4.

4. Does the patient have a history of antineoplastic therapy in the last 365 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 5.

5. Does the patient have a diagnosis of Chronic Non-Malignant Pain (CNMP) in the last 365 days? Y N

If the answer to this question is yes, go to question 6.
If the answer to this question is no, denied.

6. Does the patient have less than or equal to 7 days of opioid therapy in the last 30 days? Y N
   If the answer to this question is yes, denied.
   If the answer to this question is no, go to question 7.

7. Does the patient have a history of monoamine oxidase inhibitor (MAOI) therapy or a strong/moderate CYP3A4 inhibitor in the last 30 days? Y N
   If the answer to this question is yes, denied.
   If the answer to this question is no, go to question 8.

8. Is the request for transmucosal fentanyl 200mcg? Y N
   If the answer to this question is yes, go to question 11.
   If the answer to this question is no, go to question 9.

9. Is the request for transmucosal fentanyl greater than or equal to 400mcg? Y N
   If the answer to this question is yes, go to question 10.
   If the answer to this question is no, denied.

10. Does the patient have a history of transmucosal fentanyl therapy in the last 30 days with a dose greater than or equal to 200 mcg? Y N
    If the answer to this question is yes, go to question 11.
    If the answer to this question is no, denied.

11. Is the requested quantity less than or equal to 4 units per day? Y N
    If the answer to this question is yes, go to question 12.
    If the answer to this question is no, denied.

12. Is this request for a non-preferred drug? Y N
    If the answer to this question is yes, go to question 13.
    If the answer to this question is no, approved for 365 days.

13. Has the patient failed a 6-day treatment trial with at least 1 preferred agent(s) within 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 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 15.

15. 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 ____________________