



Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas
Ravicti (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 Ravicti (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)
Ravicti 1.1 gram/ml liquid

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. Does the patient have a diagnosis of urea cycle disorder (UCD) in the past 730 days? Y N
2. Is this request for a non-preferred drug? Y N
3. Has the patient failed a 30-day treatment trial with at least 1 preferred agent(s) within the past 180 days? Y N

4. 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, denied.

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (or Authorized) Signature

Date