Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

Fentora (Buccal Fentanyl) (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 Fentora (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)	
FENTORA 100 MCG BUCCAL TABLET	FENTANYL CIT 100 MCG BUCCAL TABLET
FENTORA 200 MCG BUCCAL TABLET	FENTANYL CIT 200 MCG BUCCAL TABLET
FENTORA 400 MCG BUCCAL TABLET	FENTANYL CIT 400 MCG BUCCAL TABLET
FENTORA 600 MCG BUCCAL TABLET	FENTANYL CIT 600 MCG BUCCAL TABLET
FENTORA 800 MCG BUCCAL TABLET	FENTANYL CIT 800 MCG BUCCAL TABLET

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 greater than or equal to 18 years of age? Y N
   If the answer to this question is yes, go to question 3.
   If the answer to this question is no, denied.

3. Does the patient have a diagnosis of malignant cancer within the last 730 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 4.

4. Does the patient have a history of an antineoplastic agent in the last 365 days? Y N
   If the answer to this question is yes, go to question 5.
   If the answer to this question is no, denied.

5. Does the patient have a claim for a monoamine oxidase inhibitor (MAOI) or 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 6.

6. Does the patient have at least 12 days supply of opioid therapy in the last 14 days? Y N
   If the answer to this question is yes, go to question 7.
   If the answer to this question is no, denied.

7. Does the patient have a history of buccal fentanyl in the last 35 days? Y N
   If the answer to this question is yes, go to question 14.
   If the answer to this question is no, go to question 8.

8. Does the patient have a history of opioid tolerance with defined oral morphine, transdermal fentanyl, oxycodone, hydromorphone or oxymorphone in the last 30 days? Y N
   If the answer to this question is yes, go to question 9.
   If the answer to this question is no, denied.

9. Is the request for buccal fentanyl 100mcg? Y N
   If the answer to this question is yes, go to question 14.
   If the answer to this question is no, go to question 10.

10. Is the request for buccal 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 12.

11. Does the patient have a claim for Actiq 600, 800, 1200 or 1600mcg in the last 35 days? Y N
    If the answer to this question is yes, go to question 14.
    If the answer to this question is no, denied.

12. Is the request for buccal fentanyl 400mcg? Y N
    If the answer to this question is yes, go to question 13.
    If the answer to this question is no, denied.

13. Does the patient have a history of Actiq 1200 or 1600mcg in the last 35 days? Y N
    If the answer to this question is yes, go to question 14.
    If the answer to this question is no, denied.

14. Is the request for less than or equal to 4 units per day? Y N
    If the answer to this question is yes, go to question 15.
    If the answer to this question is no, denied.

15. Is this request for a non-preferred drug? Y N
    If the answer to this question is yes, go to question 16.
    If the answer to this question is no, approved for 365 days.

16. Has the patient failed a 6-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 17.

17. 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 18.

18. 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