MOLINA HEALTHCARE

Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

Hepatitis C Agents Refill (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 Hepatitis C Agents Refill (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)		
DAKLINZA (daclatasvir)	EPCLUSA (sofosbuvir/velpatasvir)	HARVONI (ledipasvir/sofosbuvir)
MAVYRET (glecaprevir and pibrentasvir)	MODERIBA (ribavirin)	OLYSIO (simeprevir)
PEGASYS (peginterferon alfa-2a)	REBETOL (ribavirin)	RIBASPHERE (ribavirin)
SOVALDI (sofosbuvir)	TECHNIVIE (ombitasvir, paritaprevir and ritonavir)	VIEKIRA (ombitasvir, paritaprevir and ritonavir and dasabuvir)
VOSEVI (sofosbuvir)	ZEPATIER (elbasvir/grazoprevir)	

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. Has the Texas CHIP Texas Vendor Drug Program Antiviral Agents for Hepatitis C Virus Refill Authorization Request been completed and submitted? Y N
   If the answer to this question is yes, go to question 2.
   If the answer to this question is no, denied.

2. Is the patient compliant with HCV treatment (has not missed more than 14 days of treatment)? Y N
   If the answer to this question is yes, go to question 3.
   If the answer to this question is no, denied.

3. Is the patient currently abusing alcohol/drugs? Y N
   If the answer to this question is yes, denied.
   If the answer to this question is no, go to question 4.

4. Has the provider submitted the required labs (and does the lab show decreased or undetected viral load at 4 weeks or 12 weeks)? Y N
   If the answer to this question is yes, approved.
   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