Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas
PDL Phosphate Binders (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 PDL Phosphate Binders (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)

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 ESRD in the past 180 days? ☐ Y ☐ N
   If the answer to this question is yes, go to question 2.
   If the answer to this question is no, denied.

2. Does the patient have a diagnosis of hyperphosphatemia in the past 180 days? ☐ Y ☐ N
   If the answer to this question is yes, go to question 3.
   If the answer to this question is no, denied.

3. Has the patient failed a 30-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, go to question 5.
   If the answer to this question is no, go to question 4.

4. Is there a documented allergy or contraindication to preferred agents in this class? ☐ 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 diagnosis of hypercalcemia in 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 6.

6. Does the patient have a history of a corrected calcium lab value > 10.2 in 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 7.

7. Does the patient have a history of consecutive PTH lab values < 150 in 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 8.

8. Does the patient have a diagnosis of dialysis in the past 180 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. Does the patient have a history of CPT codes for dialysis in the past 180 days? ☐ 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 vascular or soft tissue calcification in 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, denied.

Comments:

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

_____ _____

Prescriber (or Authorized) Signature Date