Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

GLP-1 Receptor Agonists (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 GLP-1 Receptor Agonists (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)	
ADLYXIN STARTER PACK	ADLYXIN MAINTENANCE PK
BYDUREON PEN INJECT	BYDUREON BCISE AUTOINJECT
BYETTA DOSE PEN INJ	OZEMPIC DOSE PEN
RYBELSUS TABLET	SOLIQUA PEN
TRULICITY PEN	VICTOZA PEN
XULTOPHY PEN	

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 5.
   If the answer to this question is no, go to question 3.

3. Is the requested drug Victoza? Y N
   If the answer to this question is yes, go to question 4.

If the answer to this question is no, denied.

4. Is the patient greater than or equal to 10 years of age? 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 type 2 diabetes 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 a history of an oral antidiabetic agent for 14 days in the last 365 days? Y N
   If the answer to this question is yes, go to question 8.
   If the answer to this question is no, go to question 7.

7. Does the patient have a history of the requested medication for 14 days in the last 365 days? Y N
   If the answer to this question is yes, go to question 8.
   If the answer to this question is no, denied.

8. Does the patient have a history of ESRD, chronic kidney disease (stage IV and V), pancreatitis, or gastroparesis in the last 730 days? Y N
   If the answer to this question is yes, denied.
   If the answer to this question is no, go to question 9.

9. Does the patient have a history of ESRD services (CPT codes) in the last 730 days? Y N
   If the answer to this question is yes, denied.
   If the answer to this question is no, go to question 10.

10. Does the patient have a history of an HbA1c test in the last 180 days? 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 this request for a non-preferred drug? Y N
    If the answer to this question is yes, go to question 12.
    If the answer to this question is no, approved for 365 days.

12. Has the patient failed a 14-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 13.

13. Is there a documented allergy or contraindication to preferred agents in this class? Y N
    If the answer to this question is yes, approved 365 days.
    If the answer to this question is no, go to question 14.

14. 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 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