Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas
PDE5-Inhibitors (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 PDE5-Inhibitors (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)		
ADCIRCA 20 MG TABLET	REVATIO 20 MG TABLET	REVATIO 10MG/ML ORAL SUSPENSION
SILDENAFIL 20 MG TABLET	TADALAFIL 20 MG TABLET	TADALAFIL 5 MG 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. Does the patient have a diagnosis of pulmonary hypertension (PH) in the last 180 days? Y N
   If the answer to this question is yes, go to question 6.
   If the answer to this question is no, go to question 3.

3. Is the request for tadalafil 5 mg? 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 request for a male patient? 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 benign prostatic hyperplasia (BPH) in the last 730 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 using a denial drug (nitrates, alpha blockers, tamsulosin, or lopinavir/ritonavir) in the past 45 days? Y N
   If the answer to this question is yes, denied.
   If the answer to this question is no, go to question 7.

7. Does the patient have a history of a denial diagnoses (sickle cell disorders, multiple myeloma, leukemia or cardiac condition) in the last 180 days? Y N
   If the answer to this question is yes, denied.
   If the answer to this question is no, go to question 8.

8. Does the patient have a diagnosis of retinitis pigmentosa 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. Based on the patient's diagnosis, is the total daily dose less than or equal to 60 mg (PH) or 5 mg (BPH)? Y N
   If the answer to this question is yes, go to question 10.
   If the answer to this question is no, denied.

10. Is the request for a non-preferred drug? Y N
    If the answer to this question is yes, go to question 11.
    If the answer to this question is no, approved for 365 days.

11. 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 12.

12. 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 13.

13. 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