Prior Authorization Form

Molina Healthcare of Texas

Topical Immunomodulators (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 **1-866-449-6849** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Elidel and Protopic 0.03% (Medicaid).

Drug Name (select from list of drugs shown)	
Elidel	Protopic 0.03%

Patient Information	
Patient Name:	
Patient ID:	
Patient Group No.:	
Patient DOB:	

Prescribing Physician	
Physician Name:	
Physician Phone:	
Physician Fax:	
Physician Address:	
City, State, Zip:	

Diagnosis:	ICD Code:

Please circle the appropriate answer for each question.

1. Is the patient less than or equal to 2 years of age? Y N
   If the answer to this question is yes, go to question 2.
   If the answer to this question is no, skip to question 3.

2. Does the patient have a history of a topical steroid or nystatin/triamcinolone prescription in the last 730 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. Does the patient have a diagnosis of atopic dermatitis in the last 730 days? Y N
   If the answer to this question is yes, go to question 4.
   If the answer to this question is no, denied.

4. Does the patient have a history of a topical steroid or nystatin/triamcinolone prescription in the last 90 days? Y N
   If the answer to this question is yes, skip to question 6.
   If the answer to this question is no, go to question 5.

5. Does the patient have a history of a prior pimecrolimus/tacrolimus prescription 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 diagnosis of HIV or immune system disorder 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 7.

7. Does the patient have a history of HIV drugs or immunosuppressants 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 8.

8. Does the patient have a history of antineoplastic agents 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 a prior pimecrolimus/tacrolimus prescription in the last 365 days? Y N
   If the answer to this question is yes, go to question 10.
   If the answer to this question is no, approved for 6 weeks.

10. Does the patient have a history of pimecrolimus/tacrolimus prescription less than or equal to 84 days in the last 112 days? Y N
    If the answer to this question is yes, denied.
    If the answer to this question is no, approved for 12 weeks.

Comments:

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

____ ________________________

Prescriber (or Authorized) Signature Date