Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

Ophthalmic 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 **1-855-322-4080** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Ophthalmic Immunomodulators (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)	
CEQUA 0.09% SOLUTION	RESTASIS MULTIDOSE 0.05%
RESTASIS 0.05% EYE EMULSION	XIIDRA 5% EYE DROPS

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 dry eye syndrome or keratoconjunctivitis sicca in the last 730 days? Y N
   If the answer is yes, go to question 3.
   If the answer is no, denied.

3. Is this request for continuation of therapy? Y N
   If the answer is yes, go to question 5.
   If the answer is no, go to question 4.

4. Is the medication being prescribed by, or in conjunction with, an ophthalmologist or optometrist? Y N
   If the answer is yes, go to question 5.
   If the answer is no, denied.

5. Is the patient less than 16 years of age? Y N
   If the answer is yes, denied
   If the answer is no, go to question 6.

6. Is the request for Restasis? Y N
   If the answer is yes, go to question 7.
   If the answer is no, go to question 8.

7. Is the patient greater than or equal to 16 years of age? Y N
   If the answer is yes, go to question 12.
   If the answer is no, denied.

8. Is the request for Xiidra? Y N
   If the answer is yes, go to question 9.
   If the answer is no, go to question 10.

9. Is the patient greater than or equal to 17 years of age? Y N
   If the answer is yes, go to question 12.
   If the answer is no, denied.

10. Is the request for Cequa? Y N
    If the answer is yes, go to question 11.
    If the answer is no, denied.

11. Is the patient greater than or equal to 18 years of age? Y N
    If the answer is yes, go to question 12.
    If the answer is no, denied.

12. Is the requested quantity less than or equal to the recommended dosing guidelines (see Table A)? Y N
    If the answer is yes, go to question 13.
    If the answer is no, denied.

13. Is this request for a non-preferred drug? Y N
    If the answer is yes, go to question 14.
    If the answer is no, approved for 365 days.

14. Has the patient failed a 180-day treatment trial with at least 1 preferred agent within the past 200 days? Y N
    If the answer is yes, approved for 365 days.
    If the answer is no, go to question 15.

15. Is there a documented allergy or contraindication to preferred agents in this class? Y N
    If the answer is yes, approved for 365 days.
    If the answer is no, go to question 16.

16. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions? Y N
    If the answer is yes, approved for 365 days.
    If the answer is no, denied.

Table A
Dosing Guidelines

Label Name	Recommended Dose
Cequa, Restasis or Xiidra	60 vials per 30 days
Restasis multidose bottle	5.5 mL per 30 days

Comments:

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

_____ _____

Prescriber (or Authorized) Signature Date