



Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas Gaucher's Disease Agents (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 Gaucher's Disease Agents (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)		
CERDELGA 84MG CAPSULE	CEREZYME 400 UNITS VIAL	ELELYSO 200 UNITS VIAL
MIGLUSTAT 100MG CAPSULE	VPRIV 400 UNITS VIAL	ZAVESCA 100MG CAPSULE

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.

- 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.
- Does the patient have a diagnosis of Gaucher's disease 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.
- Is the patient currently pregnant? Y N
If the answer to this question is yes, denied.
If the answer to this question is no, go to question 4.
- Does the patient have 1 claim for a medication for Gaucher's disease (excluding the incoming claim) in the last 14 days? Y N
If the answer to this question is yes, denied.

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

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| 5. Is this request for a non-preferred drug? | Y | N |
| <i>If the answer to this question is yes, go to question 6.</i> | | |
| <i>If the answer to this question is no, approved for 365 days.</i> | | |
| 6. Has the patient failed a treatment trial with at least 1 preferred agent? | Y | N |
| <i>If the answer to this question is yes, approved for 365 days.</i> | | |
| <i>If the answer to this question is no, go to question 7.</i> | | |
| 7. Is there a documented allergy or contraindication to preferred agents in this class? | Y | N |
| <i>If the answer to this question is yes, approved for 365 days.</i> | | |
| <i>If the answer to this question is no, go to question 8.</i> | | |
| 8. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions? | Y | N |
| <i>If the answer to this question is yes, approved for 365 days.</i> | | |
| <i>If the answer to this question is no, denied.</i> | | |

Comments:

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

Prescriber (or Authorized) Signature

Date