Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

Arikayce (Amikacin) (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 Arikayce (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)
ARIKAYCE 590 MG/8.4 ML VIAL

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 3.
   If the answer to this question is no, denied.

3. Does the patient have a diagnosis of Mycobacterium avium complex (MAC) lung disease 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. Has the patient had therapy with at least two of the drugs listed in Table A (below) for at least 180 days in the last 365 days prior to requesting therapy with Arikayce? Y N
   If the answer to this question is yes, go to question 5.
   If the answer to this question is no, denied.

5. Is Arikayce being prescribed concurrently with at least 2 of the drugs listed in Table A (below)? Y N
If the answer to this question is yes, go to question 6.
If the answer to this question is no, denied.

6. Is this request for a non-preferred drug? Y N
If the answer to this question is yes, go to question 7.
If the answer to this question is no, approved for 365 days.

7. Has the patient failed a treatment trial with at least 1 preferred agent? 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 8.

8. 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 9.

9. 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.

Table A:

AZITHROMYCIN 100 MG/5 ML SUSP
AZITHROMYCIN 200 MG/5 ML SUSP
AZITHROMYCIN 250 MG TABLET
AZITHROMYCIN 500 MG TABLET
AZITHROMYCIN 600 MG TABLET
AZITHROMYCIN I.V. 500 MG VIAL
AZITHROMYCIN 1 GM PWD PACKET
BAXDELA 450 MG TABLET
CIPRO 250 MG TABLET
CIPRO 500 MG TABLET
CIPROFLOXACIN 250 MG/5 ML
CIPROFLOXACIN 500 MG/5 ML
CIPROFLOXACIN HCL 100 MG TAB
CIPROFLOXACIN HCL 250 MG TAB
CIPROFLOXACIN HCL 500 MG TAB
CIPROFLOXACIN HCL 750 MG TAB
CIPROFLOXACIN 200 MG/100 ML – D5W
CIPROFLOXACIN 400 MG/100 ML – D5W
CLARITHROMYCIN 125 MG/5 ML SUSPENSION
CLARITHROMYCIN 250 MG TABLET
CLARITHROMYCIN 250 MG/5 ML SUSPENSION

CLARITHROMYCIN 500 MG TABLET
CLARITHROMYCIN ER 500 MG TABLET
ETHAMBUTOL HCL 100 MG TABLET
ETHAMBUTOL HCL 400 MG TABLET
ISONIAZID 100 MG TABLET
ISONIAZID 300 MG TABLET
ISONIAZID 50 MG/5 ML
LEVOFLOXACIN 25 MG/ML SOLUTION
LEVOFLOXACIN 250 MG TABLET
LEVOFLOXACIN 500 MG TABLET
LEVOFLOXACIN 750 MG TABLET
LEVOFLOXACIN 750 MG/150 ML-D5W
LEVOFLOXACIN 500 MG/100 ML-D5W
LEVOFLOXACIN 250 MG/50 ML-D5W
MOXIFLOXACIN HCL 400 MG TABLET
MYCOBUTIN 150 MG CAPSULE
RIFABUTIN 150 MG CAPSULE
RIFAMPIN 150 MG CAPSULE
RIFAMPIN 300 MG CAPSULE
ZITHROMAX 100 MG/5 ML SUSP
ZITHROMAX 200 MG/5 ML SUSP
ZITHROMAX 250 MG TABLET
ZITHROMAX 500 MG TABLET
ZITHROMAX I.V. 500 MG VIAL

Comments:

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

_____ _____

Prescriber (or Authorized) Signature Date