Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

Cytokine and CAM Antagonists – Cimzia (Certolizumab pegol) (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 Cimzia (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)	
CIMZIA 200MG/ML SYRINGE KIT	CIMZIA 200MG/ML STARTER KIT

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 Crohn's disease (CD) 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, go to question 6.

4. Has the patient had a 30-day treatment trial of conventional therapy for Crohn's disease in the last 180 days? Y N

   <u>Conventional Therapy – Crohn's Disease</u>
   AZATHIOPRINE

CORTEF
CYCLOSPORINE
CYCLOSPORINE MODIFIED
DEXAMETHASONE
GENGRAF
HYDROCORTISONE
IMURAN
MEDROL
MERCAPTOPURINE
METHOTREXATE
METHYLPREDNISOLONE
MILLIPRED
NEORAL
OTREXUP
PREDNISOLONE
PREDNISONE
PURIXAN
SANDIMMUNE
TREXALL
VERIPRED
XATMEP

If the answer to this question is yes, go to question 7.
If the answer to this question is no, go to question 5.

5. Is the request for continuation of therapy? Y N
If the answer to this question is yes, go to question 7.
If the answer to this question is no, go to question 6.

6. Does the patient have a diagnosis of ankylosing spondylitis (AS), non-radiographic axial spondyloarthritis (nr-axSpA), plaque psoriasis (PS), psoriatic arthritis, plaque psoriasis (PsA), and/or rheumatoid arthritis (RA) in the last 730 days? Y N
If the answer to this question is yes, go to question 7.
If the answer to this question is no, denied.

7. Does the patient have a history of a demyelinating disease (e.g., multiple sclerosis, optic neuritis, Guillain-Barre syndrome) in the last 365 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 heart failure in the last 365 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 serious active infection (including Hepatitis B virus and/or tuberculosis) 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 10.

10. Does the patient have a history of hematologic abnormalities in the last 60 days? Y N
If the answer to this question is yes, denied.
If the answer to this question is no, go to question 11.

11. Does the patient have 1 claim for a contraindicated drug in the last 30 days? Y N

Contraindicated Drugs
KINERET 100 MG/0.67 ML SYRINGE

ORENCIA 125 MG/ML SYRINGE
RITUXAN 10 MG/ML VIAL
TYSABRI 300 MG/15 ML VIAL

If the answer to this question is yes, denied.
If the answer to this question is no, go to question 12.

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

13. Has the patient failed a 30-day treatment 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 14.

14. 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 15.

15. 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