Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

Cytokine and CAM Antagonists – Simponi (Golimumab) (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 Simponi (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)		
SIMPONI 100 MG/ML PEN INJECTOR	SIMPONI 100 MG/ML SYRINGE	SIMPONI 50 MG/0.5 ML PEN INJECTOR
SIMPONI 50MG/0.5 ML SYRINGE	SIMPONI ARIA 50 MG/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 4.
   If the answer to this question is no, go to question 3

3. Is the request for Simponi Aria? Y N
   If the answer to this question is yes, go to question 7.
   If the answer to this question is no, denied.

4. Does the patient have a diagnosis of rheumatoid arthritis in the last 730 days? Y N
   If the answer to this question is yes, go to question 6.

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

5. Does the patient have a diagnosis of ankylosing spondylitis (AS), psoriatic arthritis (PsA), and/or ulcerative colitis (UC) in the last 730 days? Y N
   If the answer to this question is yes, go to question 9.
   If the answer to this question is no, denied.

6. Does the patient have 1 claim for methotrexate in the last 60 days? Y N

   Methotrexate
   METHOTREXATE
   OTREXUP
   TREXALL
   XATMEP

   If the answer to this question is yes, go to question 9.
   If the answer to this question is no, denied.

7. Is the patient greater than or equal to 2 years of age? Y N
   If the answer to this question is yes, go to question 8.
   If the answer to this question is no, denied.

8. Does the patient have a diagnosis of polyarticular juvenile idiopathic arthritis (PJIA) or psoriatic arthritis (PsA) in the last 730 days? Y N
   If the answer to this question is yes, go to question 9.
   If the answer to this question is no, denied.

9. 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 10.

10. Does the patient have a history of demyelinating disease (multiple sclerosis, optic neuritis, and/or 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 11.

11. Does the patient have a history of hematologic abnormalities 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 12.

12. 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 13.

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

    Simponi – Contraindicated Drugs
    CIMZIA
    ENBREL
    HUMIRA
    KINERET

    If the answer to this question is yes, denied.
    If the answer to this question is no, go to question 14.

14. Is this request for a non-preferred drug? Y N
    If the answer to this question is yes, go to question 15.
    If the answer to this question is no, approved for 365 days.

15. 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 16.

16. 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 17.

17. 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