Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

Cytokine and CAM Antagonists – Humira (Adalimumab) (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 Humira (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)		
HUMIRA (CF) 10 MG/0.1 ML SYRINGE	HUMIRA (CF) 20 MG/0.2 ML SYRINGE	HUMIRA (CF) 40 MG/0.4 ML SYRINGE
HUMIRA (CF) PEDI CROHN 80 MG/0.8	HUMIRA (CF) PEDI CROHN 80-40MG	HUMIRA (CF) PEN 40 MG/0.4 ML
HUMIRA (CF) PEN CRHN-UC-HS 80 MG	HUMIRA (CF) PEN PS-UV-AHS 80-40 MG	HUMIRA 10 MG/0.2 ML SYRINGE
HUMIRA 20 MG/0.4 ML SYRINGE	HUMIRA 40 MG/0.8 ML SYRINGE	HUMIRA PEN 40 MG/0.8 ML
HUMIRA PEN CROHN-UC-HS 40 MG	HUMIRA PEN PS-UV-ADOL HS 40 MG	

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 ankylosing spondylitis (AS), plaque psoriasis (PS), psoriatic arthritis (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, go to question 3.

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 9.
If the answer to this question is no, go to question 4.

4. Does the patient have a diagnosis of ulcerative colitis (UC) in the last 730 days? Y N
If the answer to this question is yes, go to question 10.
If the answer to this question is no, go to question 5.

5. Does the patient have a diagnosis of juvenile idiopathic arthritis (JIA) or uveitis (UV) in the last 730 days? Y N
If the answer to this question is yes, go to question 11.
If the answer to this question is no, go to question 6.

6. Does the patient have a diagnosis of hidradenitis suppurativa (HS) in the last 730 days? Y N
If the answer to this question is yes, go to question 8.
If the answer to this question is no, denied.

7. 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 14.
If the answer to this question is no, denied.

8. Is the patient greater than or equal to 12 years of age? Y N
If the answer to this question is yes, go to question 14.
If the answer to this question is no, denied.

9. Is the patient greater than or equal to 6 years of age? Y N
If the answer to this question is yes, go to question 14.
If the answer to this question is no, denied.

10. Is the patient greater than or equal to 5 years of age? Y N
If the answer to this question is yes, go to question 12.
If the answer to this question is no, denied.

11. 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 14.
If the answer to this question is no, denied.

12. Has the patient had at least a 30 day trial with conventional therapy in the last 180 days? Y N

Conventional Therapy – Crohn's Disease
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 14.
If the answer to this question is no, go to question 13.

13. Is the request for continuation of therapy? Y N
If the answer to this question is yes, go to question 14.
If the answer to this question is no, denied.

14. 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 15.

15. 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 16.

16. 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 17.

17. 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 18.

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

TNF Blocker
CIMZIA
ENBREL
SIMPONI
SIMPONI ARIA

If the answer to this question is yes, denied.
If the answer to this question is no, go to question 19.

19. Is this request for a non-preferred drug? Y N
If the answer to this question is yes, go to question 20.
If the answer to this question is no, approved for 365 days.

20. Has the patient failed a 30-day treatment trial 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 21.

21. Is there a documented allergy or contraindication to preferred agents in the 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 22.

22. 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