



Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas
Topical Immunomodulators - Elidel and Protopic 0.03% (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 Topical Immunomodulators- Elidel and Protopic 0.03% (Medicaid).

Table with 3 columns: Drug Name (select from list of drugs shown / provide drug information), ELIDEL 1% CREAM, PROTOPIC 0.03% OINTMENT, TACROLIMUS 0.03% OINTMENT

Table with 2 columns: Patient Information, Patient Name, Patient ID, Patient DOB

Table with 2 columns: Prescribing Physician, Physician Name, Physician Phone, Physician Fax, Physician Address, City, State, Zip

Table with 2 columns: 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 180 days.
If the answer to this question is no, go to question 2.
2. Is the patient less than 2 years of age? Y N
If the answer to this question is yes, denied.
If the answer to this question is no, go to question 3.
3. Does the patient have a claim for a topical steroid in the last 730 days? Y N
If the answer to this question is yes, go to question 5.
If the answer to this question is no, go to question 4.
4. Does the patient have a claim for pimecrolimus or tacrolimus prescription in the last 90 days? Y N
If the answer to this question is yes, go to question 5.
If the answer to this question is no, denied.
5. Does the patient have a diagnosis of atopic dermatitis 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, denied.*

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| 6. Has the patient had a diagnosis of HIV or immune system disorder in the last 730 days?
<i>If the answer to this question is yes, denied.
If the answer to this question is no, go to question 7.</i> | Y | N |
| 7. Does the patient have a history of HIV drugs or immunosuppressants in the last 730 days?
<i>If the answer to this question is yes, denied.
If the answer to this question is no, go to question 8.</i> | Y | N |
| 8. Does the patient have a history of antineoplastic agents in the last 730 days?
<i>If the answer to this question is yes, denied.
If the answer to this question is no, go to question 9.</i> | Y | N |
| 9. Does the patient have a diagnosis of a skin absorption disorder or a skin malignancy in the last 730 days?
<i>If the answer to this question is yes, denied.
If the answer to this question is no, go to question 10.</i> | Y | N |
| 10. Does the patient have claims history of prior pimecrolimus or tacrolimus use for less than or equal to 180 days in the last 200 days?
<i>If the answer to this question is yes, go to question 11.
If the answer to this question is no, denied.</i> | Y | N |
| 11. Is the request for a non-preferred drug?
<i>If the answer to this question is yes, go to question 12.
If the answer to this question is no, approved for 180 days.</i> | Y | N |
| 12. Has the patient failed a 30-day treatment trial with at least 1 preferred agent within the last 60 days?
<i>If the answer to this question is yes, approved for 180 days.
If the answer to this question is no, go to question 13.</i> | Y | N |
| 13. Is there a documented allergy or contraindication to preferred agents in this class?
<i>If the answer to this question is yes, approved for 180 days.
If the answer to this question is no, go to question 14.</i> | Y | N |
| 14. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
<i>If the answer to this question is yes, approved for 180 days.
If the answer to this question is no, denied.</i> | Y | N |

Comments:

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

Prescriber (or Authorized) Signature

Date