Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

Cytokine and CAM Antagonists – Siliq (Brodalumab) (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 Siliq (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)
SILIQ 210 MG/1.5 ML SYRINGE

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 16 weeks.
   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 moderate to severe plaque psoriasis (PS) 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. Does the patient have a history of 30 days conventional therapy for plaque psoriasis (PS) in the last 180 days? Y N

<u>Conventional Therapy for Plaque Psoriasis</u>

ASTAGRAF XL
AZATHIOPRINE
CALCIPOTRIENE
CALCIPOTRIENE-BETAMETH DP
CELLCEPT
CIMZIA
CYCLOSPORINE
CYCLOSPORINE MODIFIED
DOVONEX
ENBREL
ENVARSUS XR
FABIOR
GENGRAF
HUMIRA
IMURAN
METHOTREXATE
MYCOPHENOLATE
MYCOPHENOLIC ACID
MYFORTIC
NEORAL
OTREXUP
PROGRAF
SANDIMMUNE
SORILUX
STELARA
TABLOID
TACLONEX
TACROLIMUS
TAZAROTENE
TAZORAC
TREXALL
XATMEP

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. Is the request for continuing therapy? Y N
If the answer to this question is yes, go to question 6.
If the answer to this question is no, denied.

6. Does the patient have a claim for another biologic drug in the last 30 days? Y N

Biologic DMARDs
ACTEMRA
CIMZIA
COSENTYX
ENBREL
HUMIRA
ILARIS
KEVZARA
KINERET
ORENCIAA
OTEZLA
SIMPONI
SIMPONI ARIA
STELARA

TALTZ
TREMFYA

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

7. Does the patient have a diagnosis of Crohn's disease (CD) 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 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 9.

9. Is this request for a non-preferred drug? Y N
If the answer to this question is yes, go to question 10.
If the answer to this question is no, approved for 16 weeks.

10. 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 16 weeks.
If the answer to this question is no, go to question 11.

11. 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 16 weeks.
If the answer to this question is no, go to question 12.

12. 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 16 weeks.
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