Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

Topical Immunomodulators- Protopic 0.1% (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- Protopic 0.1% (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)	
PROTOPIC 0.1% OINTMENT	TACROLIMUS 0.1% OINTMENT

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 180 days.
   If the answer to this question is no, go to question 2.

2. Is the patient less than 16 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 history of a prior 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.

6. Has the patient had a diagnosis of HIV or immune system disorder in the last 730 days? Y N
   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 history of HIV drugs or immunosuppressants in the last 730 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 antineoplastic agents in the last 730 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 diagnosis of a skin absorption disorder or a skin malignancy in the last 730 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 claims history of prior pimecrolimus or tacrolimus use for less than or equal to 180 days in the last 200 days? Y N
    If the answer to this question is yes, go to question 11.
    If the answer to this question is no, denied.

11. Is the request for a non-preferred drug? Y N
    If the answer to this question is yes, go to question 12.
    If the answer to this question is no, approved for 180 days.

12. Has the patient failed a 30-day treatment trial with at least 1 preferred agent within the last 60 days? 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 13.

13. 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 180 days.
    If the answer to this question is no, go to question 14.

14. 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 180 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