Prior Authorization Request Form for Cytokine and CAM Antagonists

FAX this completed form to (844) 205-3386
OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720
OR Prior authorization may be completed at https://www.covermymeds.com/main/prior-authorization-forms/

I. PROVIDER INFORMATION	II. MEMBER INFORMATION
Prescriber Name:	Member Name:
Prescriber Specialty:	Identification #:
NPI:	Group #:
Office Contact Name:	Date of Birth:
Fax #:	Medication Allergies:
Phone #:	

III. DRUG INFORMATION (One drug request per form)		
Drug name and strength:	Dosage Interval (sig):	Qty. per Day:

IV. REQUIRED DOCUMENTION *(Detailed medical record documentation demonstrating evidence for each item must be submitted with prior authorization request)*

Specify diagnosis & diagnosis code relevant to this request: Dx/Dx Code: _____

Does the member have any contraindications to the prescribed medication?	☐ Yes ☐ No *Submit documentation.*
Requests for all non-preferred medications: Does the member have a history of trial and failure of or contraindication or intolerance to the preferred Cytokine and CAM Antagonist? **Has a current history (within the past 90 days) of being prescribed the same non-preferred Cytokine and CAM Antagonist (does not apply to non-preferred brands when the therapeutically equivalent generic is preferred or to non-preferred generics when the therapeutically equivalent brand is preferred [NOTE: biosimilars are NOT therapeutically equivalent generics]** *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.*	☐ Yes ☐ No *Submit documentation of previous trials/failures, contraindications, and/or intolerances or current use.*

☐ If requesting for daily quantity exceeding daily limit (Refer to https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx), please provide supporting information:_____

SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.

- ☐ If not prescribed by one of the following specialist, gastroenterologist, dermatologist, rheumatologist, ophthalmologist, immunologist, genetic specialist, pulmonologist, oncologist etc., please indicate a specialist consulted:_____
- ☐ If currently using a different Cytokine and CAM Antagonist, one of the following:
  - ☐ Will discontinue use of that Cytokine and CAM Antagonist prior to starting the requested Cytokine and CAM Antagonist
  - ☐ One of the following:
    - ☐ Has medical reason for concomitant use of both Cytokine and CAM Antagonist that is supported by peer-reviewed literature or national treatment guidelines
    - ☐ Is dependent on glucocorticoids in addition to a Cytokine and CAM Antagonist to prevent life-threatening complications
    - ☐ Has 2 or more autoimmune or autoinflammatory conditions for which a single Cytokine and CAM Antagonist is not sufficient

- ☐ For Cytokine and CAM Antagonist associated with an increased risk of infection according to FDA-approved package labeling, was evaluated for both of the following:
  - ☐ Active or latent tuberculosis infection documented by results of tuberculin skin test (purified protein derivative) or blood test (interferon-gamma release assay)
  - ☐ Hepatitis B virus infection documented by results of anti-HBs, HBsAg, and anti-HBc
- ☐ For Cytokine and CAM Antagonist associated with behavioral and/or mood changes according to FDA-approved package labeling (e.g., Otezla, Siliq):
  - ☐ Member was evaluated for a history of prior suicide attempt, bipolar disorder, or major depressive disorder

SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.

ADULT-ONSET STILL'S DISEASE:

- ☐ For treatment of adult-onset Still's disease, one of the following:
  - ☐ Has predominantly systemic disease and one of the following:
    - ☐ Has history of therapeutic failure of or a contraindication or an intolerance to systemic glucocorticoids (medication, start date and end date):_____
    - ☐ Both of the following:
      - ☐ Has glucocorticoid-dependent Still's disease (medication, start date):_____
      - ☐ Will be using the requested Cytokine and CAM Antagonist with the intent of discontinuing or decreasing the dose of systemic glucocorticoid
  - ☐ Has predominantly joint disease and one of the following:
    - ☐ A history of therapeutic failure of a conventional non-biologic disease-modifying antirheumatic drug (DMARD) (medication, start date and end date):_____
    - ☐ A contraindication or an intolerance to conventional non-biologic DMARD:_____

ANKYLOSING SPONDYLITIS & OTHER AXIAL SPONDYLOARTHRITIS:

- ☐ For treatment of ankylosing spondylitis or other axial spondyloarthritis, has one of the following:
- ☐ A history of therapeutic failure of a 2-week trial of continuous treatment with 2 different oral non-steroidal anti-inflammatory drugs (NSAIDs) (i.e., an oral NSAID taken daily for 2 weeks and a different oral NSAID taken daily for 2 weeks)(medication, start date and end date):_____
- ☐ Has a contraindication or an intolerance to oral NSAIDs:_____

ATOPIC DERMATITIS:

- ☐ For treatment of moderate to severe chronic atopic dermatitis, has a history of therapeutic failure of at least two of the following OR a contraindication or an intolerance to all of the following:
  - ☐ One of the following:
    - ☐ For the treatment of the face, skin folds, or other critical areas, a low-potency topical corticosteroid (medication, start date and end date):_____
    - ☐ For treatment of other areas, a medium-potency or higher topical corticosteroid (medication, start date and end date):_____
  - ☐ A topical calcineurin inhibitor (medication, start date and end date):_____
  - ☐ Phototherapy in accordance with current consensus guidelines (start date and end date):_____
  - ☐ Systemic immunosuppressives in accordance with current consensus guidelines (e.g., cyclosporine, azathioprine, methotrexate, mycophenolate mofetil) (medication, start date and end date):_____

BEHCET'S SYNDROME:

- ☐ For treatment of Behcet's syndrome, all of the following:
  - ☐ Has a diagnosis of Behcet's syndrome according to current consensus guidelines
  - ☐ Has recurrent oral ulcers associated with Behcet's syndrome
  - ☐ Has a history of therapeutic failure of or a contraindication or an intolerance to a topical corticosteroid (e.g., triamcinolone dental paste) (medication, start date and end date):_____
  - ☐ Has one of the following:
    - ☐ A history of therapeutic failure of at least 3-month trial of colchicine at maximally tolerated doses (medication dose, start date and end date):_____
    - ☐ A contraindication or an intolerance to colchicine:_____

CHRONIC PSORIASIS:

- ☐ For the treatment of moderate to severe chronic psoriasis, all of the following:
  - ☐ Has psoriasis associated with at least one of the following:

- ☐ A body surface area (BSA) of ≥ 3% that is affected:_____
- ☐ A BSA of less than 3% that is affected with involvement of critical areas (e.g., hands, feet, scalp, face, genitals, nails and intertriginous areas):_____
- ☐ Significant disability or impaired physical or mental functioning:_____

☐ Has one of the following:
- ☐ A history of therapeutic failure of topical corticosteroids OR other topical pharmacologic therapy (e.g., anthralin, calcineurin inhibitors, tar, tazarotene, vitamin D analogs) (medication, start date and end date):_____
- ☐ A contraindication or an intolerance to topical corticosteroids OR other topical pharmacologic therapy (medication, start date and end date):_____
- ☐ Moderate to severe nail disease

☐ Has a history of therapeutic failure of or a contraindication or an intolerance to at least one of the following:
- ☐ A 3-month trial of oral systemic therapy (e.g., methotrexate, cyclosporine, acitretin) (medication, start date and end date):_____
- ☐ Ultraviolet light therapy (e.g., NB-UVB, BB-UVB, PUVA, excimer laser) (start date and end date):_____

CROHN'S DISEASE:

☐ For treatment of Crohn's disease, one of the following:

☐ For a diagnosis of moderate to severe Crohn's disease, one of the following:
- ☐ Failed to achieve remission with or has a contraindication or intolerance to an induction course of corticosteroids (medication, start date and end date):_____
- ☐ One of the following:
  - ☐ Failed to maintain remission with or has a contraindication or intolerance to an immunomodulators in accordance with current consensus guidelines (medication, start date and end date):_____
  - ☐ Has a contraindication or intolerance to an immunomodulators in accordance with current consensus guidelines:_____

☐ Has a diagnosis of Crohn's disease that is associated with one or more high-risk or poor prognostic features (e.g., onset of symptoms at <30 years of age, extensive anatomic involvement, presence of fistula, perianal and/or severe rectal disease, large or deep mucosal lesions on endoscopy or imaging, prior surgical resection, stricturing and/or penetrating behavior, need for steroid therapy at initial diagnosis, extra-intestinal manifestations, laboratory markers such as low hemoglobin, low albumin, high C-reactive protein, high fecal calprotectin levels, severe growth delay):_____

☐ Both of the following:
- ☐ Has achieved remission with the requested Cytokine and CAM Antagonist
- ☐ Will be using the requested medication as maintenance therapy to maintain remission

FAMILIAR MEDITERRANEAN FEVER:

☐ For treatment of familial Mediterranean fever, has one of the following:
- ☐ A history of therapeutic failure of at least 3-month trial of colchicine at maximally tolerated doses (medication dose, start date and end date):_____
- ☐ A contraindication or an intolerance to colchicine:_____

GAINT CELL ARTERITIS:

☐ For treatment of giant cell arteritis, one of the following:
- ☐ Has a history of therapeutic failure of or a contraindication or an intolerance to systemic glucocorticoids (medication, start date and end date):_____
- ☐ Is at high risk for glucocorticoid-related complications:_____
- ☐ Both of the following:
  - ☐ Has glucocorticoid-dependent disease:_____
  - ☐ Will be using the requested Cytokine and CAM Antagonist with the intent of discontinuing or decreasing the dose of systemic glucocorticoid

HIDRADENITIS SUPPURATIVA (HS):

☐ For treatment of moderate to severe hidradenitis suppurativa (HS), one of the following:

☐ Both of the following:
- ☐ Has Hurley stage II or III disease
- ☐ Has a history of therapeutic failure of or contraindication or an intolerance to both of the following:

- ☐ A 3-month trial of topical Clindamycin (start date and end date):_____
- ☐ An adequate trial of a systemic antibiotic (e.g., doxycycline, minocycline, or tetracycline; clindamycin; clindamycin + rifampin; rifampin + moxifloxacin + metronidazole; rifampin + levofloxacin + metronidazole; amoxicillin/clavulanate) (medication, start date and end date):_____

☐ Both of the following:
- ☐ Has Hurley stage III disease
- ☐ Is a candidate for or has a history of surgical intervention for HS

JUVENILE IDIOPATHIC ARTHRITIS (JIA):

☐ For treatment of juvenile idiopathic arthritis (JIA), one of the following:

☐ Has one of the following:
- ☐ A history of therapeutic failure of a 3-month trial of a conventional non-biologic disease-modifying antirheumatic drug (DMARD) in accordance with current consensus guidelines (e.g., leflunomide, methotrexate, cyclosporine, etc) (medication, start date and end date):_____
- ☐ A contraindication or an intolerance to non-biologic DMARDs

☐ Has systemic JIA with active systemic features (e.g., fever, evanescent rash, lymphadenopathy, hepatomegaly, splenomegaly, and serositis):_____

☐ Has a diagnosis of JIA that is associated with both of the following:
- ☐ One or more risk factors for disease severity (e.g., positive anti-cyclic citrullinated peptide antibodies, positive rheumatoid factor, presence of joint damage):_____
- ☐ At least one of the following:
  - ☐ Involvement of high-risk joints (e.g., cervical spine, hip, wrist)
  - ☐ High disease activity
  - ☐ Is at high risk of disabling joint damage as judged by the prescriber

☐ Has active sacroilitis and/or enthesitis and one of the following:
- ☐ A history of therapeutic failure of a 2-week trial of an oral non-steroidal anti-inflammatory drug (NSAID)
- ☐ A contraindication or an intolerance to oral NSAIDs

PSORIATIC ARTHRITIS:

☐ For the treatment of active psoriatic arthritis (e.g., swollen joints, tender joints, dactylitis, enthesitis, axial disease, active skin and/or nail involvement, and extraarticular inflammatory manifestations such as uveitis or IBD), one of the following:

☐ Has axial disease and/or enthesitis

☐ Has peripheral disease and one of the following:
- ☐ A history of therapeutic failure of an 8-week trial of a conventional non-biologic disease-modifying antirheumatic drug (DMARD) (medication, start date and end date):_____
- ☐ A contraindication or an intolerance to conventional non-biologic DMARDs:_____

☐ Has severe disease as determined by the prescriber (e.g., a poor prognostic factor (erosive disease, elevated levels of inflammation markers such as C-reactive protein or erythrocyte sedimentation rate attributable to PsA), long-term damage that interferes with function (e.g., joint deformities, vision loss), highly active disease that causes major impairment in quality of life (i.e., active psoriatic inflammatory disease at many sites [including dactylitis, enthesitis] or function-limiting inflammatory disease at a few sites), and rapidly progressive disease):_____

☐ Has concomitant moderate to severe nail disease

RHEUMATOID ARTHRITIS:

☐ For treatment of moderately to severely active rheumatoid arthritis, has one of the following:
- ☐ A history of therapeutic failure of a 3-month trial of a conventional non-biologic disease-modifying antirheumatic drug (DMARD) in accordance with current consensus guidelines (e.g., azathioprine, leflunomide, methotrexate, etc) (medication, start date and end date):_____
- ☐ A contraindication or an intolerance to a conventional non-biologic DMARDs:_____

SARCOIDOSIS:

☐ For treatment of sarcoidosis, both of the following:

☐ One of the following:
- ☐ Has a history of therapeutic failure of or a contraindication or an intolerance to systemic glucocorticoid (medication, start date and end date):_____
- ☐ Has glucocorticoid-dependent sarcoidosis

- ☐ Has a history of therapeutic failure of or a contraindication or an intolerance to a conventional non-biologic disease-modifying antirheumatic drug (DMARD) (medication, start date and end date):_____

ULCERATIVE COLITIS (UC):

- ☐ For the treatment of ulcerative colitis (UC), one of the following:
  - ☐ Both of the following:
    - ☐ Has one of the following diagnoses:
      - ☐ Mild UC associated with high-risk or poor prognostic features (e.g., onset of symptoms at <40 years of age, extensive colitis, severe endoscopic disease (presence of large and/or deep ulcers), hospitalization for colitis, elevated inflammatory markers, low serum albumin, extra-intestinal manifestations, early need for corticosteroids):_____
      - ☐ Moderate to severe UC:_____
    - ☐ One of the following:
      - ☐ Failed to achieve remission with or has a contraindication or intolerance to an induction course of corticosteroids (medication, start date and end date):_____
      - ☐ One of the following:
        - ☐ Failed to maintain remission with or has a contraindication or intolerance to an immunomodulators in accordance with current consensus guidelines (medication, start date and end date):_____
        - ☐ Has a contraindication or intolerance to an immunomodulators in accordance with current consensus guidelines:_____
  - ☐ Both of the following:
    - ☐ Has achieved remission with the requested Cytokine and CAM Antagonist
    - ☐ Will be using the requested medication as maintenance therapy to maintain remission

UVEITIS (NON-INFECTIOUS):

- ☐ For treatment of non-infectious uveitis, one of the following:
  - ☐ Has a diagnosis of uveitis associated with juvenile idiopathic arthritis (JIA) or Behcet's syndrome
  - ☐ Has a history of therapeutic failure of or a contraindication or an intolerance to one of the following:
    - ☐ A systemic, topical, intraocular, or periocular corticosteroid (medication, start date and end date):_____
    - ☐ A conventional systemic immunosuppressive (e.g., azathioprine, cyclophosphamide, cyclosporine, methotrexate, mycophenolate, tacrolimus) (medication, start date and end date):_____
  - ☐ Both of the following:
    - ☐ Has corticosteroid-dependent uveitis (e.g., daily systemic corticosteroid dose equivalent to 7.5 mg or greater of prednisone in adults for six weeks or longer) (medication, start date and end date):_____
    - ☐ Will be using the requested Cytokine and CAM Antagonist with the intent of discontinuing or decreasing the dose of the systemic corticosteroid

RENEWAL REQUEST:

- ☐ One of the following:
  - ☐ Experienced improvement in disease activity and/or level of functioning since initiating therapy with the requested Cytokine and CAM Antagonist:_____
  - ☐ Is prescribed an increased dose or more frequent administration of the requested Cytokine and CAM Antagonist that is supported by peer-reviewed medical literature or national treatment guidelines

IV. ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION :

Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	Provider Signature:	Date:

Pharmacy Department will respond via fax or phone within 24 hours.
Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)