



CYTOKINE AND CAM ANTAGONISTS PRIOR AUTHORIZATION FORM (form effective 1/6/2025)

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.covermyeds.com/main/prior-authorization-forms/>

Prior authorization guidelines for **Cytokine and CAM Antagonists** and **Quantity Limits/Daily Dose Limits** are available on the PA Health & Wellness website at <https://www.pahealthwellness.com/providers/pharmacy.html>

<input type="checkbox"/> New request	<input type="checkbox"/> Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:			Specialty:	
Contact's phone number:			NPI:	State license #:
LTC facility contact/phone:			Street address:	
Member name:			City/state/zip:	
Member ID#:	DOB:	Phone:	Fax:	

CLINICAL INFORMATION

STARTER PACK requested (drug name / strength / formulation [pen, syringe, tablet, etc.]):		MAINTENANCE product/packaging requested (drug name / strength / formulation [pen, syringe, tablet, etc.]):	
Quantity per fill:	Refills:	Quantity per fill:	Refills:
Directions:		Directions:	
Diagnosis (<i>submit documentation</i>):		Dx code (<i>required</i>):	Member weight:
Is the member currently being treated with the requested medication?		<input type="checkbox"/> Yes – date of last dose: _____ <i>Submit documentation.</i> <input type="checkbox"/> No	
Is the requested medication prescribed by or in consultation with a specialist (eg, rheumatologist, dermatologist, gastroenterologist, etc.)?		<input type="checkbox"/> Yes <i>If prescriber is not a specialist, submit documentation of consultation.</i> <input type="checkbox"/> No	

Complete all sections that apply to the member and this request.

Check all that apply and submit documentation for each item.

INITIAL requests

DRUG

1. Requested drug is NON-PREFERRED on the Statewide PDL:

Tried and failed or has a contraindication or intolerance to the preferred drugs in this class approved or medically accepted for the member's condition (Refer to <https://papdl.com/preferred-drug-list> for a list of preferred and non-preferred drugs in this class.): _____

2. Requested drug is BIMZELX (bimekizumab), OTEZLA (apremilast), or SILIQ (brodalumab):

Was evaluated for history of prior suicide attempt, bipolar disorder, or major depressive disorder

3. Requested drug is an ORAL JAK INHIBITOR (eg, Olumiant [baricitinib], Rinvoq [upadacitinib], Xeljanz [tofacitinib]):

Tried and failed at least one TNF blocker or other biologic as recommended in the JAK inhibitor's package

labeling: _____

Has a contraindication or an intolerance to TNF blockers or other biologics as recommended in the JAK inhibitor's package

labeling: _____

DIAGNOSIS

1. ALL diagnoses:

Screened for hepatitis B virus infection (surface antigen, surface antibody, and core antibody) *(if recommended in the FDA-approved package labeling)*

Screened for tuberculosis *(if recommended in the FDA-approved package labeling)*

2. Adult-onset Still's disease (AOSD):

Has predominantly systemic AOSD AND:

Has steroid-dependent AOSD

Tried and failed or has a contraindication or an intolerance to systemic glucocorticoids: _____

Has predominantly joint AOSD AND:

Tried and failed or has a contraindication or an intolerance to conventional DMARDs (eg, MTX): _____

3. Alopecia areata:

Has alopecia universalis

Has >50% scalp involvement or alopecia totalis

Has alopecia that causes significant disability or impaired physical, mental, or psychosocial functioning

Has a current episode of alopecia areata that has lasted at least 6 months

4. Ankylosing spondylitis & non-radiographic axial spondyloarthritis:

Tried and failed a 2-week trial of or has a contraindication or an intolerance to 2 different oral NSAIDs: _____

5. Behçet's syndrome:

Has recurrent oral ulcers associated with Behçet's syndrome

Tried and failed or has a contraindication or an intolerance to a topical corticosteroid (eg, triamcinolone dental

paste): _____

Tried and failed a 3-month trial of colchicine at maximally tolerated doses or has a contraindication or an intolerance to

colchicine: _____

6. Crohn's disease (CD):

Has moderate-to-severe CD AND:

Tried and failed to achieve remission with or has a contraindication or an intolerance to an induction course of corticosteroids: _____

Tried and failed to maintain remission with or has a contraindication or an intolerance to conventional immunomodulators (eg, AZA, 6-MP, MTX): _____

Has CD that is associated with high-risk or poor prognostic features: _____

Has achieved remission with the requested medication AND:

Will be using the requested medication as maintenance therapy to maintain remission

7. Familial Mediterranean fever:

Tried and failed a 3-month trial of colchicine at maximally tolerated doses or has a contraindication or an intolerance to colchicine: _____

8. Generalized pustular psoriasis (GPP):

- Request is for Spevigo (spesolimab) intravenous AND:
- Is being treated for a GPP flare
 - One of the following:
 - Member has received a single dose of spesolimab for the current GPP flare AND:
 - Continues to experience moderate to severe GPP flare symptoms since the previous dose
 - Member has not received a dose of spesolimab for the current GPP flare AND:
 - Is experiencing a moderate to severe GPP flare that warrants rapid stabilization or improvement
- Request is for Spevigo (spesolimab) subcutaneous AND:
- Has a history of at least one GPP flare
 - Is using subcutaneous spesolimab for the prevention of GPP flares

9. Giant cell arteritis (GCA):

- Tried and failed or has a contraindication or an intolerance to systemic glucocorticoids: _____
- Is at high risk for glucocorticoid-related complications
- Has steroid-dependent GCA

10. Gout flares:

- Tried and failed maximally tolerated doses of or has a contraindication or an intolerance to NSAIDs: _____
- Tried and failed maximally tolerated doses of or has a contraindication or an intolerance to colchicine: _____
- Tried and failed maximally tolerated doses of or has a contraindication or an intolerance to corticosteroids: _____
- Has a medical reason why repeated courses of corticosteroids are not appropriate: _____

11. Hidradenitis suppurativa (HS):

- Has Hurley stage II or stage III HS
- Is a candidate for or has a history of surgical intervention for HS
- Tried and failed a 3-month trial of or has a contraindication or an intolerance to topical clindamycin: _____
- Tried and failed or has a contraindication or an intolerance to systemic antibiotics (eg, doxycycline, minocycline, tetracycline, clindamycin): _____

12. Juvenile idiopathic arthritis (JIA):

- Has systemic JIA with active systemic features
- Has JIA associated with any of the following:

<input type="checkbox"/> Positive anti-CCP antibodies	<input type="checkbox"/> Presence of joint damage	<input type="checkbox"/> High disease activity
<input type="checkbox"/> Positive rheumatoid factor	<input type="checkbox"/> High risk of disabling joint damage	<input type="checkbox"/> Involvement of high-risk joints (cervical spine, hip, wrist)
- Tried and failed a 3-month trial of or has a contraindication or an intolerance to conventional DMARDs (eg, MTX): _____
- Has active sacroiliitis and/or enthesitis AND:
 - Tried and failed a 2-week trial of or has a contraindication or an intolerance to oral NSAIDs: _____

13. Plaque psoriasis:

- Has a BSA of $\geq 3\%$ that is affected
- Has involvement of critical areas of the body (eg, skin folds, face, genitals)
- Has psoriasis that causes significant disability or impaired physical, mental, or psychosocial functioning
- Has moderate-to-severe nail psoriasis
- Tried and failed a 4-week trial of or has a contraindication or an intolerance to topical corticosteroids: _____
- Tried and failed an 8-week trial of or has a contraindication or an intolerance to non-steroid topical medications (eg, anthralin, calcineurin inhibitor, tazarotene, etc): _____

14. Polymyalgia rheumatica (PMR):

- Tried and failed or has a contraindication or an intolerance to systemic glucocorticoids: _____
- Has steroid-dependent PMR

15. Psoriatic arthritis (PsA):

- Tried and failed an 8-week trial of or has a contraindication or an intolerance to conventional DMARDs (eg, AZA, leflunomide, MTX, SSZ): _____
- Has predominantly axial PsA, dactylitis, and/or enthesitis
- Has severe PsA
- Has comorbid moderate-to-severe nail psoriasis
- Has comorbid active inflammatory bowel disease

16. Rheumatoid arthritis:

- Tried and failed a 3-month trial of or has a contraindication or an intolerance to conventional DMARDs (eg, AZA, leflunomide, MTX, etc): _____

17. Sarcoidosis:

- Tried and failed or has a contraindication or an intolerance to systemic glucocorticoids: _____
- Has steroid-dependent sarcoidosis
- Tried and failed a conventional DMARD (eg, AZA, leflunomide, MTX, mycophenolate) or has a contraindication or an intolerance to conventional DMARDs: _____

18. Ulcerative colitis (UC):

- Has moderate-to-severe UC
- Has UC associated with multiple poor prognostic factors
- Tried and failed to achieve remission with or has a contraindication or an intolerance to an induction course of corticosteroids: _____
- Tried and failed to maintain remission with or has a contraindication or an intolerance to conventional immunomodulators (eg, AZA, cyclosporine, 6-MP, MTX): _____
- Has achieved remission with the requested medication AND:
 - Will be using the requested medication as maintenance therapy to maintain remission

19. Uveitis (non-infectious):

- Has comorbid juvenile idiopathic arthritis
- Has comorbid Behçet's syndrome
- Has steroid-dependent uveitis
- Tried and failed or has a contraindication or an intolerance to systemic, topical, intraocular, or periocular corticosteroids: _____
- Tried and failed or has a contraindication or an intolerance to conventional systemic immunosuppressives (eg, AZA, MTX, MMF, etc): _____

20. Other diagnosis: _____

- List other treatments tried (including start/stop dates, dose, outcomes): _____

RENEWAL requests

- Experienced an improvement in disease severity or level of functioning since starting therapy with the requested medication
- Is prescribed an increased dose or more frequent administration of the requested medication (supporting evidence if outside FDA limit): _____
- Requested drug is BIMZELX (bimekizumab), OTEZLA (apremilast), or SILIQ (brodalumab):
 - Was recently reevaluated for behavioral and mood changes

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO 844-205-3386



Prescriber Signature:

Date:

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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.)