Prior Authorization Request Form for Cytokine and CAM Antagonists

FAX this completed form to (877) 386-4695

OR Mail requests to: Envolve Pharmacy Solutions PA Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720

I. PROVIDER INFORMATION	II. MEMBER INFORMATION
Prescriber Name:	Member Name:
Prescriber Specialty:	Identification #:
Office Contact Name:	Group #:
Group 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.*
All potential drug interactions have been addressed by the prescriber such as discontinuation or dose reduction of interacting medication or counseling the member about the risks associated with the use of both interacting medications,	☐ 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? *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, etc., please indicate a specialist consulted:_____
- ☐ The requested medication will NOT be use concurrently with another Cytokine and CAM Antagonist
- ☐ For Cytokine and CAM Antagonist associated with an increased risk of infection according to FDA-approved package labeling:
  - ☐ Member is up to date with immunizations in accordance with CDC Advisory Committee on Immunization Practices (ACIP) OR
  - ☐ Has a plan for receiving CDC ACIP recommended immunizations
  - ☐ Member was evaluated for active or latent tuberculosis infection documented by results of tuberculin skin test or blood test
  - ☐ Member has completed hepatitis B immunization series OR
  - ☐ Member has had hepatitis B screening (sAb, sAg and cAb)
  - ☐ If screening indicates a risk of hepatitis B virus reactivation, a follow-up plan to address this risk OR
  - ☐ If negative for hepatitis B, a plan for vaccination against hepatitis B virus

- ☐ For Cytokine and CAM Antagonist associated with behavioral and/or mood changes according to FDA-approved package labeling:
  - ☐ Member was evaluated for a history of prior suicide attempt, bipolar disorder, or major depressive disorder
  - ☐ Member will be monitored for behavioral and mood changes as recommended in the FDA approved package labeling

SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.

ADULT-ONSET STILL'S DISEASE:

- ☐ Member has predominantly systemic disease:
  - ☐ Member has steroid-dependent disease and will be using requested medication with the intent of discontinuation or decreasing the dose of systemic steroids
  - ☐ Member has tried and failed or has a contraindication or intolerance to corticosteroids (medication, start date and end date):_____
- ☐ Member has predominantly joint disease:
  - ☐ Member has tried and failed or has a contraindication or intolerance to conventional non-biologic DMARDs (eg, Methotrexate)(medication, start date and end date):_____

ANKYLOSING SPONDYLITIS & NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS:

- ☐ Member has tried and failed a 2 week trial or has a contraindication or intolerance to 2 different oral NSAIDs (medication, start date and end date):_____

BEHCET'S SYNDROME:

- ☐ Member has recurrent oral ulcers associated with Behcet's syndrome
- ☐ Member has tried and failed or has a contraindication or intolerance to topical corticosteroids (medication, start date and end date):_____
- ☐ Member has tried and failed at least 3 month trial or has a contraindication or intolerance to colchicine (medication, start date and end date):_____

CHRONIC PSORIASIS:

- ☐ Member has moderate to severe chronic psoriasis
- ☐ Member has a BSA of ≥ 3% that is affected
- ☐ Member has involvement of critical areas of the body (eg, skin folds, face, genitals)
- ☐ Member has psoriasis causing significant disability or impaired physical or mental functioning
- ☐ Member has tried and failed 3 month trial or has a contraindication or intolerance to oral systemic therapy (eg, Azathioprine, Cyclosporine, Acitretin) (medication, start date and end date):_____
- ☐ Member has tried and failed or has a contraindication or intolerance to topical corticosteroids (medication, start date and end date):_____
- ☐ Member has tried and failed or has a contraindication or intolerance to ultraviolet light therapy (start date and end date):_____

CROHN'S DISEASE:

- ☐ Member has moderate to severe Crohn's disease
- ☐ Member has disease associated with high-risk or poor prognostic features
- ☐ Member has tried and failed to achieve remission with or has a contraindication or intolerance to an induction course of corticosteroids (medication, start date and end date):_____
- ☐ Member has tried and failed to maintain remission with or has a contraindication or intolerance to an immunomodulators (Azathioprine, Mercaptopurine, Methotrexate) (medication, start date and end date):_____
- ☐ Member has achieved remission with the requested medication and will be using as maintenance therapy to maintain remission

FAMILIAR MEDITERRANEAN FEVER:

- ☐ Member has tried and failed at least 3 month trial or has a contraindication or intolerance to colchicine (medication, start date and end date):_____

GAINT CELL ARTERITIS:

- ☐ Member has tried and failed or has a contraindication or intolerance to systemic, corticosteroids (medication, start date and end date):_____
- ☐ Member is at high risk for glucocorticoid-related complications
- ☐ Member has glucocorticoid-dependent disease and will be using requested medication with the intent of discontinuing or decreasing the dose of steroids

HIDRADENITIS SUPPURATIVA:

- ☐ Member has Hurley stage II or III disease
- ☐ Member has tried and failed 3 month trial or has a contraindication or intolerance to topical Clindamycin (medication, start date and end date):_____
- ☐ Member has tried and failed or has a contraindication or intolerance to systemic antibiotic (eg. doxycycline, minocycline, tetracycline, clindamycin) (medication, start date and end date):_____

JUVENILE IDIOPATHIC ARTHRITIS (JIA):

- ☐ Member has systemic juvenile idiopathic arthritis with active systemic features
- ☐ Member has a diagnosis of juvenile idiopathic arthritis associated with a high disease activity or one or more poor prognostic feature(s)
- ☐ Member has tried and failed a 3 month trial or has a contraindication or intolerance to conventional non-biologic DMARDs (Methotrexate)(medication, start date and end date):_____
- ☐ Member has active sacrooilitis and/or enthesitis:
  - ☐ Member has tried and failed a 2 week trial or has a contraindication or intolerance to oral NSAIDs (medication, start date and end date):_____

PSORIATIC ARTHRITIS:

- ☐ Member has severe active psoriatic arthritis
- ☐ Member has concomitant moderate to severe nail disease
- ☐ Member has predominantly axial disease and/or enthesitis:
  - ☐ Member has tried and failed a 2 week trial or has a contraindication or intolerance to 2 different oral NSAIDs (medication, start date and end date):_____
- ☐ Member has predominantly peripheral disease:
  - ☐ Member has tried and failed a 8 week trial or has a contraindication or intolerance to conventional non-biologic DMARDs (Azathioprine, Leflunomide, Methotrexate, Sulfasalazine)(medication, start date and end date):_____

RHEUMATOID ARTHRITIS:

- ☐ Member has moderate to severe active rheumatoid arthritis
- ☐ Member has tried and failed a 3 month trial or has a contraindication or intolerance to conventional DMARDs (Azathioprine, Leflunomide, Methotrexate, etc)(medication, start date and end date):_____

ULCERATIVE COLITIS (UC):

- ☐ Member has moderate to severe ulcerative colitis
- ☐ Member has mild disease associated with high-risk or poor prognostic features
- ☐ Member has tried and failed to achieve remission with or has a contraindication or intolerance to an induction course of corticosteroids (medication, start date and end date):_____
- ☐ Member has tried and failed to maintain remission with or has a contraindication or intolerance to an immunomodulators (Azathioprine, Cyclosporine, Mercaptopurine, Methotrexate) (medication, start date and end date):_____
- ☐ Member has achieved remission with the requested medication and will be using as maintenance therapy to maintain remission

UVEITIS (NON-INFECTIOUS):

- ☐ Member has comorbid juvenile idiopathic arthritis
- ☐ Member has comorbid Behcet's syndrome
- ☐ Member has steroid-dependent disease
- ☐ Member has tried and failed or has a contraindication or intolerance to systemic, topical, intraocular or periocular corticosteroids (medication, start date and end date):_____
- ☐ Member has tried and failed or has a contraindication or intolerance to systemic immunosuppressive (Azathioprine, Methotrexate, Mycophenolate Mofetil, etc) (medication, start date and end date):_____
- ☐ Member has corticosteroid-dependent uveitis and will be using requested medication with the intent of discontinuing or decreasing the dose of steroids

ARCALYST (RILONACEPT):

- ☐ Member has tried and failed to maintain remission with or has a contraindication or intolerance to Kineret (anakinra) (medication, start date and end date):_____
- ☐ Member has taken the requested non-preferred Arcalyst in the past 90 days:_____

ILARIS (CANAKINUMAB):

- ☐ Member has tried and failed to maintain remission with or has a contraindication or intolerance to Kineret (anakinra) (medication, start date and end date):_____
- ☐ Member has taken the requested non-preferred Ilaris in the past 90 days:_____

INFLIXIMAB PRODUCT OTHER THAN AVSOLA (INFLIXIMAB-AXXQ):

- ☐ Member has tried and failed to maintain remission with or has a contraindication or intolerance to Avsola (infliximab-axxq) (medication, start date and end date):_____
- ☐ Member has taken the requested non-preferred Infliximab in the past 90 days:_____

RENEWAL REQUEST:

- ☐ Member has experienced improvement in disease activity and/or level of functioning since initiating therapy with requested medication:_____

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:

Envolve Pharmacy Solutions 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.)