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/

☐New request ☐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 (*submit documentation*):		Dx code (*required*):	Member weight:
Is the member currently being treated with the requested medication?		☐Yes – date of last dose: _____ *Submit documentation.* ☐No	
Is the requested medication prescribed by or in consultation with a specialist (eg, rheumatologist, dermatologist, gastroenterologist, etc.)?		☐Yes ☐No *If prescriber is not a specialist, submit documentation of consultation.*	

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:_____
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

ALL diagnoses:

☐ Screened for hepatitis B virus infection (surface antigen, surface antibody, and core antibody)

☐ Screened for tuberculosis

Adult-onset Still's disease (AOSD):

☐ Has predominantly systemic AOSD AND one of the following:

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

☐ Has predominantly joint AOSD AND one of the following:

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

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

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:_____

OR

☐ Has a contraindication or an intolerance to 2 different oral NSAIDs:_____

Behçet's syndrome:

☐ Has recurrent oral ulcers associated with Behçet's syndrome

One of the following:

☐ Tried and failed a topical corticosteroid (eg, triamcinolone dental paste):_____

☐ Has a contraindication or an intolerance to a topical corticosteroid (eg, triamcinolone dental paste):_____

One of the following:

☐ Tried and failed a 3-month trial of colchicine at maximally tolerated doses:_____

☐ Has a contraindication or an intolerance to colchicine:_____

Crohn's disease (CD):

☐ Has moderate-to-severe CD AND:

One of the following:

- ☐ Tried and failed to achieve remission with an induction course of corticosteroids:_____
- ☐ Has a contraindication or an intolerance to an induction course of corticosteroids:_____
- ☐ Tried and failed to maintain remission with conventional immunomodulators (eg, AZA, 6-MP, MTX):_____
- ☐ 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

Familial Mediterranean fever:

☐ Tried and failed a 3-month trial of colchicine at maximally tolerated:_____

☐ Has a contraindication or an intolerance to colchicine:_____

Generalized pustular psoriasis (GPP):

☐ Request is for Spevigo (spesolimab) AND:

☐ Member has received a single dose of Spevigo (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 Spevigo (spesolimab) for the current GPP flare AND:

☐ Is experiencing a moderate to severe GPP flare that warrants rapid stabilization or improvement

Giant cell arteritis (GCA):

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

OR

☐ Has a contraindication or an intolerance to systemic glucocorticoids:_____

☐ Is at high risk for glucocorticoid-related complications:_____

☐ Has steroid-dependent GCA

Gout flares:

One of the following:

☐ Tried and failed maximally tolerated doses of NSAIDs:_____

☐ Has a contraindication or an intolerance to NSAIDs:_____

One of the following:

☐ Tried and failed maximally tolerated doses of colchicine:_____

☐ Has a contraindication or an intolerance to colchicine:_____

One of the following:

☐ Tried and failed maximally tolerated doses of corticosteroids:_____

☐ Has a contraindication or an intolerance to corticosteroids:_____

☐ Has a medical reason why repeated courses of corticosteroids are not appropriate:_____

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 topical clindamycin:_____

☐ Has a contraindication or an intolerance to topical clindamycin:_____

☐ Tried and failed systemic antibiotics (eg, doxycycline, minocycline, tetracycline, clindamycin):_____

☐ Has a contraindication or an intolerance to systemic antibiotics (eg, doxycycline, minocycline, tetracycline, clindamycin):_____

Juvenile idiopathic arthritis (JIA):

☐ Has systemic JIA with active systemic features:_____

☐ Has JIA associated with any of the following:

☐ Positive anti-CCP antibodies ☐ Presence of joint damage ☐ High disease activity

☐ Positive rheumatoid factor ☐ High risk of disabling joint damage ☐ Involvement of high-risk joints (cervical spine, hip, wrist)

☐ Tried and failed a 3-month trial of conventional DMARDs (eg, MTX):_____

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 oral NSAIDs:_____

☐ Has a contraindication or an intolerance to oral NSAIDs:_____

Plaque psoriasis:

☐ Has a BSA of ≥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 topical corticosteroids:_____
OR
☐ Has a contraindication or an intolerance to topical corticosteroids:_____
☐ Tried and failed an 8-week trial of non-steroid topical medications (eg, anthralin, calcineurin inhibitor, tazarotene, etc):_____
OR
☐ Has a contraindication or an intolerance to non-steroid topical medications (eg, anthralin, calcineurin inhibitor, tazarotene, etc):_____

Polymyalgia rheumatica (PMR):

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

Psoriatic arthritis (PsA):

☐ Tried and failed an 8-week trial of conventional DMARDs (eg, AZA, leflunomide, MTX, SSZ):_____
☐ 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

Rheumatoid arthritis:

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

Sarcoidosis:

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

Ulcerative colitis (UC):

☐ Has moderate-to-severe UC
☐ Has UC associated with multiple poor prognostic factors:_____
☐ Tried and failed to achieve remission with an induction course of corticosteroids:_____
☐ Has a contraindication or an intolerance to an induction course of corticosteroids:_____
☐ Tried and failed to maintain remission with conventional immunomodulators (eg, AZA, cyclosporine, 6-MP, MTX):_____
☐ 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

Uveitis (non-infectious):

☐ Has comorbid juvenile idiopathic arthritis
☐ Has comorbid Behçet's syndrome
☐ Has steroid-dependent uveitis
☐ Tried and failed systemic, topical, intraocular, or periocular corticosteroids:_____

☐ Has a contraindication or an intolerance to systemic, topical, intraocular, or periocular corticosteroids:_____

☐ Tried and failed conventional systemic immunosuppressives (eg, AZA, MTX, MMF, etc):_____

☐ Has a contraindication or an intolerance to conventional systemic immunosuppressives (eg, AZA, MTX, MMF, etc):_____

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

☐ **Requested drug is BIMZELX (bimekizumab), OTEZLA (apremilast),** or **SILIQ (brodalumab):**

☐ Was recently reevaluated for behavioral and mood changes

ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION

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

Prescriber 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.)