



Request for Prior Authorization
BIOLOGICALS FOR ANKYLOSING SPONDYLITIS

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization is required for biologicals used for ankylosing spondylitis. Patients initiating therapy with a biological agent must 1) be screened for hepatitis B and C, patients with active hepatitis B will not be considered for coverage; 2) have not been treated for solid malignancies, nonmelanoma skin cancer, or lymphoproliferative malignancy within the last 5 years of starting or resuming treatment with a biological agent; 3) not have a diagnosis of congestive heart failure (CHF) that is New York Heart Association (NYHA) class III or IV and with an ejection fraction of 50% or less; and 4) be screened for latent TB infection, patients with latent TB will only be considered after one month of TB treatment and patients with active TB will only be considered upon completion of TB treatment.

Preferred

Non-Preferred

- Enbrel
Humira

- Cimzia
Cosentyx

- Remicade
Simponi

Strength Dosage Instructions Quantity Days Supply

Screening for Hepatitis B: Date: Active Disease: Yes No

Screening for Hepatitis C: Date: Active Disease: Yes No

Screening for Latent TB infection: Date: Results:

Has patient received treatment for solid malignancies, nonmelanoma skin cancer, or lymphoproliferative malignancy within last 5 years of starting or resuming treatment with a biologic agent? Yes No

Does patient have a diagnosis of NYHA class III or IV CHF diagnosis with ejection fraction of 50% or less: Yes No

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NSAID Trial #1 Name/Dose: _____ Trial start date: _____ Trial end date: _____

Reason for Failure: _____

NSAID Trial #2 Name/Dose: _____ Trial start date: _____ Trial end date: _____

Reason for Failure: _____

DMARD Trial (for peripheral arthritis diagnosis) Name/Dose: _____

Trial start date: _____ Trial end date: _____ Reason for Failure: _____

Reason for use of Non-Preferred drug requiring prior approval: _____

Other medical conditions to consider: _____

Possible drug interactions/conflicting drug therapies: _____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission
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IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.