



Request for Prior Authorization
BIOLOGICALS FOR ARTHRITIS

(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, Prescriber must complete all information above, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization is required for biologicals used for arthritis. 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

- Enbrel
Humira

Non-Preferred

- Actemra, Cimzia (prefilled syringe), Cosentyx, Ilaris, Kevzara, Kineret, Orencia, Remicade, Simponi, Stelara

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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Rheumatoid arthritis (RA) (Humira, Enbrel, Actemra, Cimzia, Kineret, Orencia, Remicade, Simponi, Kevzara)-
Payment will be considered upon a trial and inadequate response to two preferred disease modifying
antirheumatic drugs (DMARD) used concurrently. The combination must include methotrexate plus another
preferred oral DMARD (hydroxychloroquine, sulfasalazine, leflunomide, or minocycline). Upon an unsuccessful
methotrexate trial in patients with established RA, the combination trial with a second DMARD may be
overridden if there is evidence of severe disease documented by radiographic erosions.

Methotrexate trial: Dose: _____ Trial dates: _____

Failure reason: _____

Plus preferred oral DMARD trial: Drug Name & Dose: _____ Trial dates: _____

Failure reason: _____

Radiographic evidence indicating erosions: Yes No

Psoriatic arthritis, moderate to severe (Cimzia, Cosentyx, Enbrel, Humira, Remicade, Simponi, Stelara)-
Payment will be considered upon a trial and inadequate response to the preferred oral DMARD, methotrexate
(leflunomide or sulfasalazine may be used if methotrexate is contraindicated).

Methotrexate or preferred oral DMARD trial: Drug Name & Dose: _____

Trial dates: _____ Failure reason: _____

Methotrexate contraindication if applicable: _____

Juvenile idiopathic arthritis, moderate to severe (Enbrel, Humira, Actemra, Orencia, Ilaris)-

Payment will be considered upon a trial and inadequate response to intraarticular glucocorticoid injections and
the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is
contraindicated).

Intraarticular Glucocorticoid Injections: Drug Name & Dose: _____ Trial dates: _____

Failure reason: _____

Plus methotrexate or preferred oral DMARD trial: Drug Name & Dose: _____

Trial dates: _____ Failure reason: _____

Methotrexate contraindication if applicable: _____

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

Other medical conditions to consider: _____

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.