Iowa Department of Human Services

Request for Prior Authorization
BIOLOGICALS FOR ARTHRITIS

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

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. It must be legible, correct, and complete or form will be returned.

Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for biologicals used for arthritis. Request must adhere to all FDA approved labeling. Payment for non-preferred biologicals for arthritis will be considered only for cases in which there is documentation of previous trials and therapy failures with two preferred biological agents. Payment will be considered under the following conditions: 1) Patient has been 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; and 2) Patient has been screened for hepatitis B and C. Patients with evidence of active hepatitis B infection (hepatitis surface antigen positive > 6 months) must have documentation they are receiving or have received effective antiviral treatment.
In addition to the above:
Requests for TNF Inhibitors: 1) Patient has 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; and 2) Patient does 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.
Requests for Interleukins: Medication will not be given concurrently with live vaccines.
The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Preferred
- ☐ Cosentyx (after Humira trial)
- ☐ Enbrel
- ☐ Humira

Non-Preferred
- ☐ Actemra
- ☐ Cimzia (prefilled syringe)
- ☐ Ilaris
- ☐ Kevzara
- ☐ Kineret
- ☐ Orencia
- ☐ Remicade
- ☐ Simponi
- ☐ Stelara
- ☐ Taltz

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: _____

Requests for TNF Inhibitors:

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 lll or lV CHF diagnosis with ejection fraction of 50% or less? ☐ Yes ☐ No

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Requests for Interleukins:

Will medication be given concurrently with live vaccines? ☐ Yes ☐ No

☐ **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 (hydroxychoroquine, sulfasalazine, or leflunomide). 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, Taltz)- 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

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.*