



Request for Prior Authorization
BIOLOGICALS FOR INFLAMMATORY BOWEL DISEASE

(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 inflammatory bowel disease. Request must adhere to all FDA approved labeling. Payment for non-preferred biologicals for inflammatory bowel disease will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent.

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

- Humira
Humira Starter Kit

Non-Preferred

- Cimzia (prefilled syringe)
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:

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 III or IV CHF diagnosis with ejection fraction of 50% or less? Yes No

Requests for Interleukins:

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DISEASE**

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Will medication be given concurrently with live vaccines? Yes No

Crohn’s Disease – Payment will be considered following an inadequate response to two preferred conventional therapies including aminosalicylates (mesalamine, sulfasalazine), azathioprine/6-mercaptopurine, and/or methotrexate.

Trial Drug Name/Dose: _____ Trial dates: _____

Reason for failure: _____

Trial Drug Name/Dose: _____ Trial dates: _____

Reason for failure: _____

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

Ulcerative colitis (moderate to severe) – Payment will be considered following an inadequate response to two preferred conventional therapies including aminosalicylates and azathioprine/6-mercaptopurine.

Trial Drug Name/Dose: _____ Trial dates: _____

Reason for failure: _____

Trial Drug Name/Dose: _____ Trial dates: _____

Reason for failure: _____

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

Possible drug interactions/conflicting drug therapies/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.