



Request for Prior Authorization
BIOLOGICALS FOR ARTHRITIS

FAX Completed Form To
(800) 574-2515
Provider Help Desk
(877) 776-1567

(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 arthritis. Request must adhere to all FDA approved labeling, including age, indication, dosing, and contraindications. 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.

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

- Enbrel, Humira, Kineret, Orenzia ClickJect, Simponi, Taltz (after step through one preferred TNF)

Non-Preferred

- Actemra, Cimzia (prefilled syringe), Cosentyx, Ilaris, Kevzara, Orenzia Prefilled Syringe, Skyrizi, Stelara, Humira Biosimilar: Drug Name

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:

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**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:**

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

**Rheumatoid arthritis (RA); with**

Documentation of a trial and inadequate response, at a maximally tolerated dose, with methotrexate (hydroxychloroquine, sulfasalazine, or leflunomide may be used if methotrexate is contraindicated).

Drug Name & Dose: \_\_\_\_\_ Trial dates: \_\_\_\_\_

Failure reason: \_\_\_\_\_

**Psoriatic arthritis, moderate to severe; with**

Documentation of a trial and inadequate response, at a maximally tolerated dose, with methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated).

Drug Name & Dose: \_\_\_\_\_ Trial dates: \_\_\_\_\_

Failure reason: \_\_\_\_\_

**Juvenile idiopathic arthritis, moderate to severe; with**

Documentation of a trial and inadequate response to intraarticular glucocorticoid injections and methotrexate at a maximally tolerated dose (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: \_\_\_\_\_

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 Health and Human Services, that the member continues to be eligible for Medicaid.