

## 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)

for requested drug and indication, including age, dosing, contraindications, warnings and precautions, dru interactions, and use in specific populations. 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 biologica agents.  The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.  Preferred							
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 labelin for requested drug and indication, including age, dosing, contraindications, warnings and precautions, dru interactions, and use in specific populations. 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 biologicagents.  Preferred   Orencia Click ect   Actemra   Ilaris   Skyrizi     Enbrel   Orencia Click ect   Actemra   Ilaris   Skyrizi     Enbrel   Introduction   Introduction   Syringe   Introduction   Syringe     Humira   Simponi   Cosentyx   Orencia Prefilled Syringe     Humira Biosimilar: Drug Name   Days Supply     Rheumatoid arthritis (RA); 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:   Trial dates:     Drug Name & Dose:   Trial dates:   Trial date	IA Medicaid Member ID #	Patient name		DOB			
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Failure reason:	Documentation of a trial and inade sulfasalazine may be used if methot Drug Name &Dose:	quate response, at a maximally tolerated derexate is contraindicated).		`			

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☐ Juvenile idiopathic arthritis with oligoarthritis; with	
Documentation of a trial and inadequate response to intraarticular glucocortic maximally tolerated dose (leflunomide or sulfasalazine may be used if methotr	
Intraarticular Glucocorticoid Injections: Drug Name & Dose:	Trial dates:
Failure reason:	
Plus methotrexate or preferred oral DMARD trial: Drug Name & Dos Trial dates:Failure reason:	
Polyarticular juvenile idiopathic arthritis (pJIA), moderate to several	ere; with
Documentation of a trial and inadequate response, at a maximally tolerated do sulfasalazine may be used if methotrexate is contraindicated).	ose, with methotrexate (leflunomide or
Drug Name &Dose:Trial dates:	
Failure reason:	
Systemic juvenile idiopathic arthritis (sJIA)	
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 Health and Human Services, that the member continues to be eligible for Medicaid.

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