IOWA Health and Human Services

Request for Prior Authorization BIOLOGICALS FOR AXIAL SPONDYLOARTHRITIS

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 (PA) is required for biologicals used for axial spondyloarthritis conditions. Request must adhere to all approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations. Payment will be considered under the following conditions:

1. Patient has a diagnosis of ankylosing spondylitis (AS) or nonradiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation; and

2. Patient has documentation of an inadequate response to at least two preferred non-steroidal anti-inflammatories (NSAIDs) at maximum therapeutic doses, unless there are documented adverse responses or contraindications to NSAID use. These trials should be at least one month in duration: and

3. Patients with symptoms of peripheral arthritis must also have failed a 30-day treatment trial with at least one conventional disease modifying antirheumatic drug (DMARD), unless there is a documented adverse response or contraindication to DMARD use. DMARDs include sulfasalazine and methotrexate; and

4. Requests for non- preferred biologicals for axial spondyloarthritis conditions will be considered only for cases in which there is documentation of previous trials and therapy failures with two preferred biological agents that are FDA approved or compendia indicated for the submitted diagnosis, when applicable.

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Preferred

- ☐ Enbrel
- ☐ Humira
- ☐ Simponi
- ☐ Taltz (after step through one preferred TNF)

Non-Preferred

- ☐ Adalimumab adaz
- ☐ Adalimumab fkjp
- ☐ Cimzia
- ☐ Cosentyx
- ☐ Humira Biosimilar: Drug Name_____

Strength	Dosage Instructions	Quantity	Days Supply

Diagnosis: _____

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NSAID Trial #1 Name/Dose:_____ Trial start date:_____ Trial end date: _____
Reason for Failure: _____

NSAID Trial #2 Name/Dose:_____ Trial start date:_____ Trial end date: _____
Reason for Failure: _____

DMARD Trial (for peripheral arthritis diagnosis) Name/Dose:_____
Trial start date:_____ Trial end date:_____ Reason for Failure:_____

Medical or contraindication reason to override trial requirements: _____
_____

Other medical conditions to consider: _____

Possible drug interactions/conflicting drug therapies:_____

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.*