

Request for Prior Authorization BIOLOGICALS FOR HIDRADENITIS SUPPURATIVA

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 FDA approved or compendia indicated for the treatment of Hidradenitis Suppurativa (HS). Payment for non-preferred biologic agents will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred biologic agent.

Payment will be considered under the following conditions: 1) Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in special populations. 2) Patient has a diagnosis of moderate to severe HS with Hurley Stage II or III disease; and 3) Patient has at least three (3) abscesses or inflammatory nodules; and 4) Patient has documentation of adequate trials and therapy failures with the following: a) Daily treatment with topical clindamycin; b) Oral clindamycin plus rifampin; c) Maintenance therapy with a preferred tetracycline. If criteria for coverage are met, initial requests will be given for 4 months. Additional authorizations will be considered upon documentation of clinical response to therapy. Clinical response is defined as at least a 50% reduction in total abscess and inflammatory nodule count with no increase in abscess count and no increase in draining fistula count from initiation of therapy. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

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Preferred	Non-Preferred				
Adalimumab-aacf	Cosentyx				
Adalimumab-adbm	Other Humira Biosimilar:				
🗌 Adalimumab-fkjp					
🗌 Humira					
🗌 Simlandi					
Yusimry					
Strength	Dosage Instructions	Quantity	Days Supply		
Diagnosis:					
🗌 Hidradenitis Suppurativa: Hurley Stage 🔲 I 🔄 II 📄 III					
Other:					
Does patient have at least	three (3) absesses or inflammatory ne	odules?			
No Yes: Abscess/	Nodule count:	Date ob	tained:		

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Topical Clindamycin Trial Name/Dose:	Trial dates:	
Reason for failure:		
Oral Clindamycin Plus Rifampin Trial:		
Clindamycin: Dose:	Trial dates:	
Reason for failure:		
Rifampin: Dose:	Trial dates:	
Reason for failure:		
Maintenance Preferred Tetracycline Trial:		
Name/Dose:	Trial dates:	
Reason for failure:		
Renewals		
Document response to therapy:		
Abscess/Nodule Count: Increase Decrease (provide count):	Date obtained:	
Has patient had an increase in draining fistula count since initiation o	of therapy? 🗌 No 📄 Yes	
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.