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EXPIRED

HEALTHCARE PROVIDER ADMINISTERED BIOLOGIC IMMUNOMODULATORS
Preauthorization Request
(Preauthorization is not a guarantee of payment)

SECTION I – General Information

Today's Date: Fax completed form to:**1-866-805-4150 toll free**	☐ New request ☐ Re-Authorization

Level of Urgency:

Standard Request (Routine Care)—Care/treatment that is not emergent, urgent, or preventive in nature.

Expedited Request—Care/treatment that is emergent or the application of the timeframe for making Standard/Routine or nonlife-threatening care determinations:

- Could seriously jeopardize the life, health, or safety of the member or others, due to the member's psychological state, or
- In the opinion of the practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

For Expedited Request, Please Explain:

SECTION II – Member Information

Patients Name:	Member ID:	**Patient Information**: DOB: Sex: Age: Weight: ☐ lbs. ☐ Kg Will the patient self-administer the requested medication? ☐ Yes ☐ No
Patients Address:	Is CBC primary payer: ☐ Yes ☐ No	

Plan Type:

☐ PPO ☐ POS ☐ KHPC ☐ CHIP (aka Capital Cares 4Kids)

☐ Traditional ☐ Comprehensive ☐ Special Care ☐ Other* _____

NOTE: For all Medicare Advantage products, please contact Prime Therapeutics at https://www.covermymeds.com/main or via phone at 1-866-260-0452.

SECTION III – Provider Information Required

Requesting Provider Name: **Address**:	**Requesting Provider CBC #**_____ **NPI #** _____
Telephone #:	Secure Fax #:
Office Contact Name:	Office Contact Telephone #:

Is the Rendering/Servicing provider different? ☐ No ☐ Yes – Complete rendering provider information below.

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Rendering Provider Name: **Telephone:** **Address**: **Telephone:**	**Rendering Provider CBC #**_____ **NPI #** _____

Site of Service: ☐ MD Office ☐ Home Health ☐ Non-hospital affiliated, outpatient infusion center ☐ Hospital affiliated, outpatient infusion center ☐ Other: Specify _____ **Please refer to MP 3.016 for Site of Service requirements.*	**Check all that apply and include all applicable documentation:** ☐ There are contraindications to a less intensive site of care. ☐ A less intensive site of care is not appropriate for the patient's condition. ☐ Patient is being treated with a drug that cannot be administered in a less intensive site of care concurrently. ☐ Less intensive site of care is not available. **Please include all applicable documentation.*

SECTION IV – Preauthorization Requirements and Clinical Criteria

Prescribed in consultation with a specialist? ☐ Yes Specialty: _____ ☐ No

☐ New to therapy ☐ Continuing therapy*: Initial start ☐ Reinitiating therapy: Last treatment *Please include documentation for changes in dose.	**Route of Administration:** ☐ Intravenous (IV) ☐ Injection (Sub Q or IM) ☐ Oral (PO) or Enteral ☐ Other: Specify _____
HCPC Code(s):	**Diagnosis Code(s)**:
Medication requested:	**Indication:**

Type of drug requested: ☐ Brand name ☐ Generic ☐ Biosimilar ☐ Other: Specify _____

Initial start date of therapy:	Anticipated date of **next administration:**

Dosing period for request: Start Date: End Date	**Dosing Information:** Dose: Strength: Frequency: Quantity requested per month:

Attach documentation demonstrating the medical nessicity of the requested drug. Please list all reasons for selecting the requested medication, strength, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max.)

Has the patient had **medical testing** completed for use of this drug? (labs, imagining) ☐ Yes ☐ No

Results:_____

Is drug being requested for an "**off label" indication**? ☐ Yes ☐ No

If yes, please see Medical Policy 2.103 and include any applicable documentation.

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Please list any previous medications that were **tried and failed**. Include reason for discontinuation (intolerance, hypersensitivity, inadequate response etc.). Please attach documentation.

Drug(s) and strength:

Documentation of failure:

Healthcare Provider Administered (HCPA) Biologic Immunomodulator

☐ Actemra (tocilizumab)
☐ Cimzia (certolizumab pegol)
☐ Ilumya (tidrakizumab)
☐ Inflectra (infliximab-dyyb)
☐ Renflexis (infliximab-abda)
☐ Stelara (ustekinumab)
☐ Orencia (abatacept)
☐ Simponi ARIA (golimumab)
☐ Remicade (infliximab)
☐ Entyvio (vedolizumab)
☐ Inflectra (infliximab -dyyb)
☐ Avsola (infliximab-axxq)
☐ Taltz (ixekizumab)

What is the patient's diagnosis?

☐ Moderately to severely active rheumatoid arthritis (RA)
☐ Granulomatosis with polyangiitis (GPA) (Wegener's granulomatosis)
☐ Active psoriatic arthritis (PsA)
☐ Chronic severe plaque psoriasis (PS)
☐ Moderately to severely active Crohn's disease (CD)
☐ Moderately to severely active ulcerative colitis (UC)
☐ Active ankylosing spondylitis (AS)
☐ Cytokine Release Syndrome (CRS)
☐ Giant Cell Arteritis (GCA)
☐ Hidradenitis Suppurativa (HS)
☐ Juvenile Idiopathic Arthritis (JIA)
☐ Polyarticular Juvenile Idiopathic Arthritis (PJIA)
☐ Other: Specify_____

Has the patient been tested for latent tuberculosis (TB)? If so, results were:

☐ Negative
☐ Positive: if positive has the patient begun therapy for latent TB? ☐ Yes ☐ No

Has the patient tried and had an inadequate response to maximally tolerated methotrexate (e.g., titrated to 25 mg weekly) for at least 3-months? ☐ Yes ☐ No

Has the patient tried and had an inadequate response to another conventional agent used in the treatment of RA (e.g., hydroxychloroquine, leflunomide, sulfasalazine) for at least 3-months? ☐ Yes ☐ No Will the requested agent be used in combination with methotrexate or an alternative DMARD (e.g. leflunomide, hydroxychloroquine, sulfasalazine, etc)? ☐ Yes ☐ No

Does the patient have refractory or treatment-resistance GPA? ☐ Yes ☐ No

Will the requested agent be used in combination with a corticosteroid? ☐ Yes ☐ No

Has the patient tried and had an inadequate response to BOTH cyclophosphamide and rituximab for at least 3-months? ☐ Yes ☐ No

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Has the patient tried and had an inadequate response to an alternative immunosuppressive (e.g. azathioprine, methotrexate, or mycophenolate mofetil) for at least 3-months? ☐ Yes ☐ No

Has the patient tried and had an inadequate response to ONE conventional agent used in the treatment of PsA (e.g., cyclosporine, leflunomide, methotrexate, sulfasalazine) for at least 3-months? ☐ Yes ☐ No

Does the patient have severe active PsA (e.g., erosive disease, elevated markers of inflammation attributable to PsA, long-term damage that interferes with function [i.e., joint deformities], rapidly progressive)? ☐ Yes ☐ No

Does the patient have concomitant severe psoriasis (PS) (e.g., greater than 10% body surface area involvement, occurring on select locations [i.e., hands, feet, scalp, face, or genitals], intractable pruritus, serious emotional consequences)? ☐ Yes ☐ No

Does the patient have severe active PS (e.g., greater than 10% body surface area involvement, occurring on select locations [i.e., hands, feet, scalp, face], intractable pruritus, serious emotional consequences)? ☐ Yes ☐ No

Does the patient have concomitant severe psoriasis (PsA) (e.g., erosive disease, elevated markers of inflammation [e.g., ESR, CRP] attributable to PsA, long-term damage that interferes with function [i.e., joint deformities], rapidly progressive)? ☐ Yes ☐ No

Has the patient tried and had an inadequate response to ONE conventional agent used in the treatment of CD (e.g., 6-mercaptopurine, azathioprine, corticosteroids [e.g., prednisone, budesonide EC capsule], methotrexate, sulfasalazine) for at least 3-months? ☐ Yes ☐ No

Has the patient tried and had an inadequate response to ONE conventional agent used in the treatment of UC (e.g., 6-mercaptopurine, azathioprine, balsalazide, corticosteroids, cyclosporine, mesalamine, steroid suppositories, sulfasalazine) for at least 3-months? ☐ Yes ☐ No

Has the patient tried and had an inadequate response to ONE conventional agent used in the treatment of PS (e.g., acitretin, anthralin, calcipotriene, calcitriol, coal tar products, cyclosporine, methotrexate, pimecrolimus, PUVA [phototherapy], tacrolimus, tazarotene, topical corticosteroids) for at least 3-months? ☐ Yes ☐ No

Has the patient tried and had an inadequate response to two different NSAIDs for at least a 4-weeks? ☐ Yes ☐ No

Is the patient currently being treated with another biologic immunomodulator agent? ☐ Yes ☐ No

Will the other biologic immunomodulator agent be discontinued prior to starting the requested agent? ☐ Yes ☐ No

For renewals: Has the patient had clinical benefit with the requested agent? ☐ Yes ☐ No

Does the patient have severely active ulcerative colitis? ☐ Yes ☐ No

Does the patient have an FDA labeled contraindation to an above listed drug? Specify:_____

***Include all applicable documentation for request.**

Please use a separate form for each drug.

To fill out form type or write using blue or black ink

Please fax this form to: 1-866-805-4150

Telephone: 1-800-471-2242

Prior authorization is not a guarantee of payment; benefits and eligibility will apply at the time of claim adjudication.