Alabama Medicaid Pharmacy
DMARD/Biological Injectables Prior Authorization Request Form

FAX: (800) 748-0116
Phone: (800) 748-0130

Fax or Mail to
Health Information Designs

P.O. Box 3210
Auburn, AL 36823-3210

PATIENT INFORMATION

Patient name _____ Patient Medicaid # _____

Patient DOB _____ Patient phone # with area code _____

PRESCRIBER INFORMATION

Prescriber name _____ NPI # _____ License # _____

Phone # with area code _____ Fax # with area code _____

Address (Optional) _____

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I will be supervising the patient's treatment. Supporting documentation is available in the patient record.

_____
Prescribing Practitioner Signature **Date**

CLINICAL INFORMATION

Drug Requested: ❒ **Actemra** ❒ **Arava** ❒ **Cimzia** ❒ **Cosentyx** ❒ **Enbrel** ❒ **Entyvio** ❒ **Humira** ❒ **Inflectra** ❒ **Kineret** ❒ **Myalept** ❒ **Nucala** ❒ **Orencia** ❒ **Otezla** ❒ **Remicade** ❒ **Siliq** ❒ **Simponi** ❒ **Stelara** ❒ **Taltz** ❒ **Xeljanz**

NDC/J Code _____ Strength _____ Qty. _____ Days' Supply _____

Current weight: _____ ICD-10 Code _____ Number of Refills _____

Please check the appropriate diagnosis below and answer diagnosis specific questions:

❒ **Ankylosing spondylitis (AS)**

- Is therapy approved by a board certified rheumatologist? ❒ Yes ❒ No
- Has the patient failed a 3 month treatment trial with at least 2 NSAIDs? If yes, attach documentation. ❒ Yes ❒ No
- For symptomatic peripheral arthritis, has the patient failed a 30-day treatment trial with at least one nonbiologic DMARD? If yes, attach documentation. ❒ Yes ❒ No

❒ **Crohn's disease (CD) or ulcerative colitis (UC)**

- Is therapy approved by a board certified gastroenterologist? ❒ Yes ❒ No
- Has the patient failed a 30-day treatment trial with at least one or more conventional therapies? If yes, attach documentation. ❒ Yes ❒ No
- For Entyvio or Stelara, has the patient failed a 30-day treatment trial with at least one of the following: a tumor necrosis factor blocker, immunomodulator, or corticosteroid? If yes, attach documentation. ❒ Yes ❒ No

❒ **Severe Asthma**

- Is therapy approved by a board certified pulmonologist or allergist? ❒ Yes ❒ No
- Has the patient had a positive blood or sputum test for asthma with an eosinophilic phenotype? If yes, indicate blood eosinophil count or sputum eosinophil count_____ ❒ Yes ❒ No
- Is the patient symptomatic despite receiving a combination of either inhaled corticosteroid and a leukotriene inhibitor or an inhaled corticosteroid and long acting beta agonist, or has the patient required 3 or more bursts of oral steroids within the past 12 months? Include past therapies_____ ❒ Yes ❒ No

❒ **Generalized Lipodystrophy**

- Is the request for treatment of complications of lipodystrophy, liver disease, HIV-related lipodystrophy, or general obesity not associated with generalized lipodystrophy? ❒ Yes ❒ No
- Is therapy being used as an adjunct to dietary restrictions? ❒ Yes ❒ No

❒ **Hidradenitis Suppurativa**

- Is therapy approved by a board certified dermatologist? ❒ Yes ❒ No
- Has the patient failed a treatment trial with at least one systemic antibiotic in the past 12 months? ❒ Yes ❒ No

❒ **Juvenile idiopathic arthritis (JIA)**

- Is therapy approved by a board certified rheumatologist? ❒ Yes ❒ No
- Has the patient failed a 30-day treatment trial with at least one nonbiologic DMARD? If yes, attach documentation. ❒ Yes ❒ No

❒ **Plaque psoriasis (PP)**

- Is therapy approved by a board certified dermatologist? ❒ Yes ❒ No
- Has the patient failed a 6 month treatment trial with at least 1 topical treatment (generic, OTC, or brand) within the past year? If yes, attach documentation. ❒ Yes ❒ No
- Has the patient had an inadequate response to phototherapy, systemic retinoids, methotrexate, or cyclosporin? ❒ Yes ❒ No

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❒ **Psoriatic arthritis (PA)**

- Is therapy approved by a board certified rheumatologist or dermatologist? ❒ Yes ❒ No
- Has the patient failed a 30-day treatment trial with at least one nonbiologic DMARD? If yes, attach documentation. ❒ Yes ❒ No

❒ **Rheumatoid arthritis (RA)**

- Is therapy approved by a board certified rheumatologist? ❒ Yes ❒ No
- Has the patient failed a 30-day treatment trial with at least one nonbiologic DMARD? If yes, attach documentation. ❒ Yes ❒ No
- For newly diagnosed moderate to severe RA (<6 months), does the patient have high disease activity with features of a poor prognosis for < 3 months **or** high disease activity for 3-6 months (without prognostic features) and therapy is being initiated with methotrexate and a biological injectable? If yes, indicate specific markers, values and features. _____ ❒ Yes ❒ No
- For Actemra, does the patient have moderate to severe RA with an inadequate response to one or more anti-TNFα therapies? ❒ Yes ❒ No

❒ **Uveitis**

- Is therapy approved by a board certified ophthalmologist? ❒ Yes ❒ No
- Has the patient failed a treatment trial with at least one topical glucocorticoid treatment within the past 12 months? ❒ Yes ❒ No

Medical Justification: _____

_____

_____

DISPENSING PHARMACY INFORMATION

May Be Completed by Pharmacy

Dispensing pharmacy _____ NPI # _____ NDC # _____

Phone # with area code _____ Fax # with area code _____