Alabama Medicaid Pharmacy
DMARD/Biological Injectables Prior Authorization Request Form

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

Fax or Mail to
Kepro

P.O. Box 3210
Auburn, AL 36831-3210

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.

_____
Prescriber Signature Date

CLINICAL INFORMATION

Drug Requested: ❒ Actemra ❒ Adbry ❒ Arava ❒ Avsola ❒ Bimzelx ❒ Cibinqo ❒ Cimzia ❒ Cinqair ❒ Cosentyx ❒ Dupixent ❒ Enbrel ❒ Entyvio ❒ Fasenra ❒ Humira ❒ Ilumya ❒ Inflectra ❒ Kevzara ❒ Kineret ❒ Lupkynis ❒ Myalept ❒ Nucala ❒ Olumiant ❒ Omvoh ❒ Orencia ❒ Otezla ❒ Remicade ❒ Renflexis ❒ Rinvoq ❒ Siliq ❒ Simponi ❒ Skyrizi ❒ Sotyktu ❒ Spevigo ❒ Stelara ❒ Taltz ❒ Tremfya ❒ Velsipity ❒ Xeljanz ❒ Zeposia ❒ Zymfentra

***If there are preferred agents indicated for the diagnoses below, the preferred agent(s) must be tried prior to approval of a non preferred agent**

Pharmacy Claim Request:

NDC/J Code_____ Strength_____ Qty._____ Days' Supply _____

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

Physician Administered/Medical Claim Request:

J Code_____ Strength_____ J Code Units_____ Days' Supply _____

Current weight:_____ ICD-10 Code _____

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

❒ Ankylosing Spondylitis (AS) or Non-Radiographic Axial Spondyloarthritis (NRAS)

- 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

❒ Atopic Dermatitis

- Is therapy approved by a board-certified dermatologist, immunologist, or allergist? ❒ Yes ❒ No
  Has the patient failed a treatment trial with at least two topical prescription treatments? ❒ Yes ❒ No
  Include past therapies_____

❒ Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)

- Does the patient have a diagnosis of CRSwNP despite prior sino-nasal surgery or treatment with, or who are ineligible to receive or were intolerant to, systemic corticosteroids? ❒ Yes ❒ No
- Is the patient currently taking an intranasal corticosteroid? ❒ 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

❒ Cryopyrin-Associated Periodic Syndrome

- Is there a diagnosis of cryopyrin-associated periodic syndrome/neonatal-onset multisystem inflammatory disease? ❒ Yes ❒ No

❒ Cytokine Release Syndrome

- Is there a diagnosis of chimeric antigen receptor (CAR) T cell-induced severe or life threatening cytokine release syndrome? ❒ Yes ❒ No

❒ Deficiency of Interleukin-1 Receptor Antagonist

- Does the patient have a diagnosis of Deficiency of Interleukin-1 Receptor Antagonist? ❒ Yes ❒ No

❒ **Enthesitis-Related Arthritis**
- Does the patient have a diagnosis of Enthesitis-Related Arthritis? ❒ Yes ❒ No

❒ **Eosinophilic Esophagitis**
- Does the patient have a diagnosis of Eosinophilic Esophagitis? ❒ Yes ❒ No

❒ **Eosinophilic/Corticosteroid-Dependent Asthma**
- Is therapy approved by a board-certified pulmonologist, immunologist, 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
- Does the patient have oral corticosteroid dependent asthma? ❒ 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 1 or more bursts of oral steroids? ❒ Yes ❒ No
  Include past therapies_____

❒ **Eosinophilic Granulomatosis with Polyangiitis**
- Is there a diagnosis of eosinophilic granulomatosis with polyangiitis? ❒ 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

❒ **Generalized Pustular Psoriasis**
- Is there a diagnosis of generalized pustular psoriasis? ❒ Yes ❒ No
- Has the patient had an inadequate response to oral retinoids, methotrexate, cyclosporine, and/or infliximab? ❒ Yes ❒ No

❒ **Graft vs. Host Disease Prophylaxis**
- Is there a diagnosis of acute graft versus host disease prophylaxis? ❒ Yes ❒ No
- Is the requested drug being used in combination with a calcineurin inhibitor and methotrexate? ❒ Yes ❒ No

❒ **Giant Cell Arteritis**
- Is there a diagnosis of giant cell arteritis? ❒ Yes ❒ No
- Is the patient currently on a glucocorticoid regimen, recently discontinued glucocorticoids, or is there a contraindication to glucocorticoid use? Indicate past/current therapies _____ ❒ 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

❒ **Lupus Nephritis**
- Does the patient have a diagnosis of active Lupus Nephritis? ❒ Yes ❒ No
- Does the patient have background immunosuppressive therapy regimen containing mycophenolate mofetil and corticosteroids? ❒ Yes ❒ No
- Does the patient have an established baseline estimated glomerular filtration rate (eGFR) >45 mL/min/1.73 m2 and blood pressure ≤165/105? ❒ Yes ❒ No

❒ **Oral Ulcers Associated with Behçet's Disease**
- Does the patient have a diagnosis of Oral Ulcers associated with Behçet's Disease? ❒ Yes ❒ No
- Has the patient had an inadequate response, adverse reaction, or contraindication to topical corticosteroids? ❒ 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

Alabama Medicaid Pharmacy
DMARD/Biological Injectables Prior Authorization Request Form

❒ **Prurigo Nodularis**

- Is there a diagnosis of Prurigo Nodularis? ❒ Yes ❒ No
- Has the patient failed a treatment trial with at least 2 topical treatments (generic, OTC, or brand)? If yes, attach documentation. ❒ Yes ❒ No
- Has the patient had an inadequate response to phototherapy? ❒ Yes ❒ No

❒ **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

❒ **Systemic Sclerosis-Associated Interstitial Lung Disease**

- Does the patient have a diagnosis of active Systemic Sclerosis-Associated Interstitial Lung Disease? ❒ 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 _____