

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 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.

Prescribing Practitioner Signature _____ Date _____

CLINICAL INFORMATION

Drug Requested: Actemra Arava Avsola Cimzia Cinqair Cosentyx Dupixent Enbrel Entyvio Fasenna Humira Ilumya Inflectra Kevzara Kineret Lupkynis Myalept Nucala Olumiant Orencia Otezla Remicade Renflexis Rinvoq Siliq Simponi Skyrizi Stelara Taltz Tremfya Xeljanz

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? Yes No
- Has the patient failed a 6-month treatment trial with at least one topical prescription treatment within the past 12 months? Include past therapies _____ Yes No

Chronic Rhinosusitis 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 in the past 2 years? 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

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Eosinophilic/Corticosteroid-Dependent 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
- 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 3 or more bursts of oral steroids within the past 12 months? Include past therapies _____ Yes No

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

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

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-TNF α 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

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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 _____