Please complete ALL information below and fax your request to 1-888-671-5285

Immune Modulating Therapy Prior Authorization Request Form (Page 1 of 9)

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

**** Medical records (e.g., chart notes, lab values) must be submitted confirming the diagnosis ****

Select the diagnosis below:

- ❑ Ankylosing spondylitis
- ❑ Atopic dermatitis
- ❑ Crohn's disease
- ❑ Cryopyrin-associated periodic syndromes (CAPS)
- ❑ Deficiency of Interleukin-1 Receptor Antagonist (DIRA)
- ❑ Enthesitis-related arthritis (ERA)
- ❑ Giant cell arteritis
- ❑ Hidradenitis suppurativa
- ❑ Multiple sclerosis
- ❑ Non-radiographic axial spondyloarthritis (nr-axSpA)
- ❑ Plaque psoriasis
- ❑ Polyarticular juvenile idiopathic arthritis (PJIA)
- ❑ Psoriatic arthritis
- ❑ Recurrent Pericarditis
- ❑ Rheumatoid arthritis (RA)
- ❑ Systemic juvenile idiopathic arthritis (SJIA)
- ❑ Systemic sclerosis-associated interstitial lung disease (SSc-ILD)
- ❑ Ulcer of the mouth associated with Behcet's syndrome
- ❑ Ulcerative colitis
- ❑ Uveitis
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

All requests:

Select if the requested medication is prescribed by or in consultation with one of the following specialists:

- ❑ Allergist
- ❑ Cardiologist
- ❑ Dermatologist
- ❑ Gastroenterologist
- ❑ Immunologist
- ❑ Ophthalmologist
- ❑ Pulmonologist
- ❑ Rheumatologist
- ❑ Other: _____

Will the patient be using the requested medication concurrently with any other biologic DMARD (i.e., tumor necrosis factor antagonists)? ❑ **Yes** ❑ **No**

Is this request for continuation of therapy with the requested product [paid claims or submission of medical records (e.g., chart notes) are required to confirm continuation of therapy]? ❑ **Yes** ❑ **No**

Ankylosing Spondylitis:

For **Cimzia** (certolizumab), **Humira** (adalimumab), or **Simponi** (golimumab) requests:

Has the patient had inadequate response or inability to tolerate two NSAIDs at maximally indicated doses [paid claims or submission of medical records (e.g., chart notes) are required]? ❑ **Yes** ❑ **No**

For **Cosentyx** (secukinumab) or **Enbrel** (etanercept) requests:

Does the patient have active disease? ❑ **Yes** ❑ **No**

Has the patient had inadequate response or inability to tolerate two NSAIDs at maximally indicated doses [paid claims or submission of medical records (e.g., chart notes) are required]? ❑ **Yes** ❑ **No**

Select if the patient has had inadequate response or inability to tolerate the following [paid claims or submission of medical records (e.g., chart notes) are required]:

- ❑ **Cimzia** (certolizumab)
- ❑ **Humira** (adalimumab)
- ❑ **Rinvoq** (upadacitinib)
- ❑ **Simponi** (golimumab)
- ❑ **Taltz** (ixekizumab)
- ❑ **Xeljanz, Xeljanz XR** (tofacitinib)

For **Rinvoq** (upadacitinib) or **Xeljanz/Xeljanz XR** (tofacitinib) requests:

Does the patient have active disease? ❑ **Yes** ❑ **No**

Has the patient had inadequate response or inability to tolerate two NSAIDs at maximally indicated doses [paid claims or submission of medical records (e.g., chart notes) are required]? ❑ **Yes** ❑ **No**

Has the patient had inadequate response or intolerance to one or more TNF inhibitors (e.g., Cimzia, Humira, Simponi) [paid claims or submission of medical records (e.g., chart notes) are required]? ❑ **Yes** ❑ **No**

For **Taltz** (ixekizumab) requests:

Does the patient have active disease? ❑ **Yes** ❑ **No**

Has the patient had inadequate response or inability to tolerate two NSAIDs at maximally indicated doses [paid claims or submission of medical records (e.g., chart notes) are required]? ❑ **Yes** ❑ **No**

Select if the patient has had inadequate response or inability to tolerate the following [paid claims or submission of medical records (e.g., chart notes) are required]:

- ❑ **Cimzia** (certolizumab)
- ❑ **Humira** (adalimumab)
- ❑ **Rinvoq** (upadacitinib)
- ❑ **Simponi** (golimumab)
- ❑ **Xeljanz, Xeljanz XR** (tofacitinib)

Reauthorization (Ankylosing Spondylitis):

Select if there is documentation of positive clinical response to therapy as evidenced by improvement from baseline of the following:

- ❑ Disease activity (e.g., pain, fatigue, inflammation, stiffness)
- ❑ Lab values (erythrocyte sedimentation rate, C-reactive protein level)
- ❑ Axial status (e.g., lumbar spine motion, chest expansion)
- ❑ Total active (swollen or tender) joint count

Atopic dermatitis:

For **Adbry** (tralokinumab-idrm) requests:

Does the patient have moderate to severe atopic dermatitis? ❑ **Yes** ❑ **No**

Select if the patient has had inadequate response or inability to tolerate the following [paid claims or submission of medical records (e.g., chart notes) are required]:

- ❑ Topical steroids, medium potency or higher
- ❑ Topical tacrolimus
- ❑ Topical Pimecrolimus

Will the patient be using the requested medication concurrently with any other biologic agents? ❑ **Yes** ❑ **No**

For **Cibinqo** (abrocitinib) or **Rinvoq** (upadacitinib) requests:

Does the patient have refractory, moderate to severe atopic dermatitis? ❑ **Yes** ❑ **No**

Select if the patient has had inadequate response or inability to tolerate the following [paid claims or submission of medical records (e.g., chart notes) are required]:

- ❑ Topical steroids, medium potency or higher
- ❑ Topical tacrolimus
- ❑ Topical Pimecrolimus

Has the patient had inadequate response or inability to tolerate ONE systemic drug product, including biologics (e.g., Dupixent) [paid claims or submission of medical records (e.g., chart notes) are required]? ❑ **Yes** ❑ **No**

Will the patient be using the requested medication concurrently with any other biologic agents (e.g., JAK inhibitors)? ❑ **Yes** ❑ **No**

Reauthorization (Atopic dermatitis):

Is there documentation of positive clinical response to therapy (e.g. reduction in body surface area involvement, reduction in pruritus severity)? ❑ **Yes** ❑ **No**

Crohn's Disease:

For **Cimzia** (certolizumab), **Humira** (adalimumab), or **Stelara** (ustekinumab) requests:

Does the patient have moderate to severe Crohn's disease? ❑ **Yes** ❑ **No**

Select if the patient has had inadequate response or inability to tolerate one drug from any of the following groups [paid claims or submission of medical records (e.g., chart notes) are required]:

- ❑ Aminosalicylates: mesalamine (Asacol, Canasa, Pentasa, Rowasa), sulfasalazine
- ❑ Antibiotics: levofloxacin, metronidazole
- ❑ Corticosteroids: budesonide (Entocort EC), hydrocortisone, methylprednisolone, prednisone
- ❑ Immunomodulators: 6-mercaptopurine, azathioprine, cyclosporine, methotrexate, tacrolimus (Prograf)

Reauthorization (Crohn's Disease):

Select if there is documentation of positive clinical response to therapy as evidenced by improvement from baseline of the following:

- ❑ Improvement in intestinal inflammation (e.g., mucosal healing, improvement of lab values [platelet counts, erythrocyte counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline
- ❑ Reversal of high fecal output state

Cryopyrin-Associated Periodic Syndromes (CAPS):

For **Arcalyst** (rilonacept) requests:

Does the patient have a diagnosis of cryopyrin-associated periodic syndromes (CAPS), including familial cold auto-inflammatory syndrome (FCAS) and/or Muckle-Wells syndrome (MWS) [submission of medical records (e.g., chart notes, lab values) is required]? ❑ **Yes** ❑ **No**

Was Arcalyst prescribed by or in consultation with an immunologist, allergist, dermatologist, rheumatologist, neurologist or other medical specialist? ❑ **Yes** ❑ **No**

For **Kineret** (anakinra) requests:

Does the patient have a diagnosis of neonatal onset multisystem inflammatory disease (NOMID) [submission of medical records (e.g., chart notes, lab values) is required]? ❑ **Yes** ❑ **No**

Reauthorization (CAPS):

For **Arcalyst** (rilonacept) requests:

Select if there is documentation of positive clinical response to therapy as evidenced by the following:

- ❑ Improvement in rash, fever, joint pain, headache, or conjunctivitis
- ❑ Decreased number of disease flare days
- ❑ Normalization of inflammatory markers (C-reactive protein [CRP], erythrocyte sedimentation rate [ESR], serum amyloid A [SAA])
- ❑ Corticosteroid dose reduction
- ❑ Improvement in MD global score or active joint count

For **Kineret** (anakinra) requests:

Is there documentation of positive clinical response to therapy? ❑ **Yes** ❑ **No**

Deficiency of Interleukin-1 Receptor Antagonist (DIRA):

For **Arcalyst** (rilonacept) requests:

Is Arcalyst being used for the maintenance of remission of Deficiency of Interleukin-1 Receptor Antagonist (DIRA)? ❑ **Yes** ❑ **No**

Is the patient currently in remission (e.g., no fever, skin rash, and bone pain; no radiological evidence of active bone lesions; C-reactive protein [CRP] less than 5 mg/L)? ❑ **Yes** ❑ **No**

Does the patient weigh at least 10kg? ❑ **Yes** ❑ **No**

Was Arcalyst prescribed by or in consultation with a rheumatologist or pediatric specialist? ❑ **Yes** ❑ **No**

For **Kineret** (anakinra) requests:

Was Kineret prescribed by or in consultation with a rheumatologist or pediatric specialist? ❑ **Yes** ❑ **No**

Reauthorization (Deficiency of Interleukin-1 Receptor Antagonist):

Is there documentation of positive clinical response to therapy? ❑ **Yes** ❑ **No**

Enthesitis-related arthritis (ERA):

For **Cosentyx** (secukinumab) requests:

Does the patient have active enthesitis-related arthritis (ERA)? ❑ **Yes** ❑ **No**

Has the patient had inadequate response or inability to tolerate two NSAIDs (e.g., ibuprofen, naproxen) at maximally indicated doses [paid claims or submission of medical records (e.g., chart notes) are required]? ❑ **Yes** ❑ **No**

Reauthorization (Enthesitis-related arthritis):

Select if there is documentation of positive clinical response to therapy as evidenced by the following:

- ❑ Reduction in the total active (swollen and tender) joint count from baseline
- ❑ Improvement in symptoms (e.g., pain, stiffness, inflammation) from baseline

Giant Cell Arteritis:

For **Actemra SQ** (tocilizumab) requests:

Has the patient had inadequate response or inability to tolerate a glucocorticoid (i.e., prednisone) [paid claims or submission of medical records (e.g., chart notes) are required]? ❑ **Yes** ❑ **No**

Reauthorization (Giant Cell Arteritis):

Is there documentation of positive clinical response to therapy? ❑ **Yes** ❑ **No**

Hidradenitis Suppurativa:

For **Humira** (adalimumab) requests:

Does the patient have moderate to severe hidradenitis suppurativa (i.e., Hurley stage II or III) [submission of medical records (e.g., chart notes, lab values) is required]? ❑ **Yes** ❑ **No**

Reauthorization (Hidradenitis Suppurativa):

Is there documentation of positive clinical response to therapy? ❑ **Yes** ❑ **No**

Multiple sclerosis:

For **Zeposia** (ozanimod) requests:

Does the patient have a relapsing form of multiple sclerosis (MS) (e.g., clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions)? ❑ **Yes** ❑ **No**

Reauthorization (Multiple sclerosis):

Is there documentation of positive clinical response to therapy (e.g., stability in radiologic disease activity, clinical relapses, disease progression)? ❑ **Yes** ❑ **No**

Non-radiographic Axial Spondyloarthritis (nr-axSpA):

For **Cimzia** (certolizumab) requests:

Does the patient have active non-radiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation? ❑ **Yes** ❑ **No**

Does the patient have objective signs of inflammation (e.g., C-reactive protein [CRP] levels above the upper limit of normal and/or sacrolitis on magnetic resonance imaging [MRI], indicative of inflammatory disease, but without definitive radiographic evidence of structural damage on sacroiliac joints)? ❑ **Yes** ❑ **No**

Has the patient had inadequate response or inability to tolerate two different NSAIDs (e.g., diclofenac, meloxicam, naproxen) at maximally indicated doses [paid claims or submission of medical records (e.g., chart notes) are required]? ❑ **Yes** ❑ **No**

For **Cosentyx** (secukinumab) requests:

Does the patient have active non-radiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation? ❑ **Yes** ❑ **No**

Does the patient have objective signs of inflammation (e.g., C-reactive protein [CRP] levels above the upper limit of normal and/or sacrolitis on magnetic resonance imaging [MRI], indicative of inflammatory disease, but without definitive radiographic evidence of structural damage on sacroiliac joints)? ❑ **Yes** ❑ **No**

Has the patient had inadequate response or inability to tolerate two different NSAIDs (e.g., diclofenac, meloxicam, naproxen) at maximally indicated doses [paid claims or submission of medical records (e.g., chart notes) are required]? ❑ **Yes** ❑ **No**

Has the patient had an inadequate response or inability to tolerate Cimzia (certolizumab) AND Taltz (ixekizumab) [paid claims or submission of medical records (e.g., chart notes) are required]? ❑ **Yes** ❑ **No**

For **Taltz** (ixekizumab) requests:

Does the patient have active non-radiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation? ❑ **Yes** ❑ **No**

Does the patient have objective signs of inflammation (e.g., C-reactive protein [CRP] levels above the upper limit of normal and/or sacrolitis on magnetic resonance imaging [MRI], indicative of inflammatory disease, but without definitive radiographic evidence of structural damage on sacroiliac joints)? ❑ **Yes** ❑ **No**

Has the patient had inadequate response or inability to tolerate two different NSAIDs (e.g., diclofenac, meloxicam, naproxen) at maximally indicated doses [paid claims or submission of medical records (e.g., chart notes) are required]? ❑ **Yes** ❑ **No**

Has the patient had an inadequate response or inability to tolerate Cimzia (certolizumab) [paid claims or submission of medical records (e.g., chart notes) are required]? ❑ **Yes** ❑ **No**

Reauthorization (Non-radiographic Axial Spondyloarthritis):

Select if there is documentation of positive clinical response to therapy as evidenced by improvement from baseline of the following:

- ❑ Disease activity (e.g., pain, fatigue, inflammation, stiffness)
- ❑ Lab values (erythrocyte sedimentation rate, C-reactive protein level)
- ❑ Function
- ❑ Axial status (e.g., lumbar spine motion, chest expansion)
- ❑ Total active (swollen and tender) joint count

Plaque Psoriasis:

For **Cimzia** (certolizumab), **Humira** (adalimumab), **Skyrizi** (risankizumab), **Stelara** (ustekinumab), or **Tremfya** (guselkumab) requests:

Does the patient have moderate to severe chronic plaque psoriasis? ❑ **Yes** ❑ **No**

Has the patient had inadequate response or inability to tolerate one of the following [paid claims or submission of medical records (e.g., chart notes) are required]: Topical calcipotriene-containing products, topical anthralin, topical steroids, topical immune modulators (Elidel, Protopic), and/or topical retinoids? ❑ **Yes** ❑ **No**

For **Cosentyx** (secukinumab) or **Enbrel** (etanercept) requests:

Does the patient have moderate to severe chronic plaque psoriasis? ❑ **Yes** ❑ **No**

Has the patient had inadequate response or inability to tolerate one of the following [paid claims or submission of medical records (e.g., chart notes) are required]: Topical calcipotriene-containing products, topical anthralin, topical steroids, topical immune modulators (Elidel, Protopic), and/or topical retinoids? ❑ **Yes** ❑ **No**

Select if the patient has had inadequate response or inability to tolerate the following [paid claims or submission of medical records (e.g., chart notes) are required]:

- ❑ **Cimzia** (certolizumab)
- ❑ **Humira** (adalimumab)
- ❑ **Skyrizi** (risankizumab)
- ❑ **Stelara** (ustekinumab)
- ❑ **Taltz** (ixekizumab)
- ❑ **Tremfya** (guselkumab)

For **Otezla** (apremilast) requests:

Has the patient had inadequate response or inability to tolerate one of the following [paid claims or submission of medical records (e.g., chart notes) are required]: Topical calcipotriene-containing products, topical anthralin, topical steroids, topical immune modulators (Elidel, Protopic), and/or topical retinoids? ❑ **Yes** ❑ **No**

For **Siliq** (brodalumab) requests:

Does the patient have moderate to severe chronic plaque psoriasis? ❑ **Yes** ❑ **No**

Has the patient had inadequate response or inability to tolerate one of the following [paid claims or submission of medical records (e.g., chart notes) are required]: Topical calcipotriene-containing products, topical anthralin, topical steroids, topical immune modulators (Elidel, Protopic), and/or topical retinoids? ❑ **Yes** ❑ **No**

Select if the patient has had inadequate response or inability to tolerate the following [paid claims or submission of medical records (e.g., chart notes) are required]:

- ❑ **Cimzia** (certolizumab)
- ❑ **Humira** (adalimumab)
- ❑ **Skyrizi** (risankizumab)
- ❑ **Stelara** (ustekinumab)
- ❑ **Taltz** (ixekizumab)
- ❑ **Tremfya** (guselkumab)

Has the patient been evaluated for depression and suicidal ideations using the Patient Health Questionnaire (PHQ)-9? ❑ **Yes** ❑ **No**

Reauthorization for Siliq:

Select if there is documentation of positive clinical response to therapy as evidenced by the following:

- ❑ Reduction in body surface area (BSA) involvement from baseline
- ❑ Improvement in symptoms (e.g., pruritus, inflammation) from baseline

Has the patient been evaluated for depression and suicidal ideations using the PHQ-9? ❑ **Yes** ❑ **No**

For **Taltz** (ixekizumab) requests:

Does the patient have moderate to severe chronic plaque psoriasis? ❑ **Yes** ❑ **No**

Has the patient had inadequate response or inability to tolerate one of the following [paid claims or submission of medical records (e.g., chart notes) are required]: Topical calcipotriene-containing products, topical anthralin, topical steroids, topical immune modulators (Elidel, Protopic), and/or topical retinoids? ❑ **Yes** ❑ **No**

Select if the patient has had inadequate response or inability to tolerate the following [paid claims or submission of medical records (e.g., chart notes) are required]:

- ❑ **Cimzia** (certolizumab)
- ❑ **Humira** (adalimumab)
- ❑ **Skyrizi** (risankizumab)
- ❑ **Stelara** (ustekinumab)
- ❑ **Tremfya** (guselkumab)

Reauthorization (Plaque Psoriasis):

Select if there is documentation of positive clinical response to therapy as evidenced by the following:

- ❑ Reduction in body surface area (BSA) involvement from baseline
- ❑ Improvement in symptoms (e.g., pruritus, inflammation) from baseline

Polyarticular Juvenile Idiopathic Arthritis (PJIA):

For **Actemra SQ** (tocilizumab), **Orencia SQ** (abatacept), or **Xeljanz** tablet and oral solution (tofacitinib) requests:

Does the patient have moderate to severe PJIA? ❑ **Yes** ❑ **No**

Has the patient had inadequate response or inability to tolerate one of the following disease-modifying anti-rheumatic drugs (DMARDs) at maximally indicated doses [paid claims or submission of medical records (e.g., chart notes) are required]: Methotrexate, hydroxychloroquine, leflunomide, azathioprine, sulfasalazine? ❑ **Yes** ❑ **No**

Has the patient had inadequate response or inability to tolerate **Humira** (adalimumab) [paid claims or submission of medical records (e.g., chart notes) are required]? ❑ **Yes** ❑ **No**

For **Enbrel** (etanercept) requests:

Does the patient have moderate to severe PJIA? ❑ **Yes** ❑ **No**

Has the patient had inadequate response or inability to tolerate one of the following disease-modifying anti-rheumatic drugs (DMARDs) at maximally indicated doses [paid claims or submission of medical records (e.g., chart notes) are required]: Methotrexate, hydroxychloroquine, leflunomide, azathioprine, sulfasalazine? ❑ **Yes** ❑ **No**

Select if the patient has had inadequate response or inability to tolerate the following [paid claims or submission of medical records (e.g., chart notes) are required]:

- ❑ **Actemra SQ** (tocilizumab)
- ❑ **Humira** (adalimumab)
- ❑ **Orencia SQ** (abatacept)
- ❑ **Xeljanz** tablets and oral solution (tofacitinib)

For **Humira** (adalimumab) requests**:**

Does the patient have moderate to severe PJIA? ❑ **Yes** ❑ **No**

Has the patient had inadequate response or inability to tolerate one of the following disease-modifying anti-rheumatic drugs (DMARDs) at maximally indicated doses [paid claims or submission of medical records (e.g., chart notes) are required]: Methotrexate, hydroxychloroquine, leflunomide, azathioprine, sulfasalazine? ❑ **Yes** ❑ **No**

Reauthorization (Polyarticular Juvenile Idiopathic Arthritis):

Select if there is documentation of positive clinical response to therapy as evidenced by the following:

- ❑ Reduction in the total active (swollen and tender) joint count from baseline
- ❑ Improvement in symptoms (e.g., pain, stiffness, inflammation) from baseline

Psoriatic Arthritis:

For **Cimzia** (certolizumab), **Humira** (adalimumab), **Otezla** (apremilast), **Simponi** (golimumab), **Stelara** (ustekinumab), **Skyrizi** (risankizumab), or **Tremfya** (guselkumab) requests:

Does the patient have active psoriatic arthritis? ❑ **Yes** ❑ **No**

For **Cosentyx** (secukinumab) requests:

Does the patient have active psoriatic arthritis? ❑ **Yes** ❑ **No**

Select if the patient has had inadequate response or inability to tolerate the following [paid claims or submission of medical records (e.g., chart notes) are required]:

- ❑ **Cimzia** (certolizumab)
- ❑ **Humira** (adalimumab)
- ❑ **Orencia SQ** (abatacept)
- ❑ **Rinvoq** (upadacitinib)
- ❑ **Simponi** (golimumab)
- ❑ **Skyrizi** (risankizumab)
- ❑ **Stelara** (ustekinumab)
- ❑ **Taltz** (ixekizumab)
- ❑ **Tremfya** (guselkumab)
- ❑ **Xeljanz/Xeljanz XR** tablets/extended-release tablets (tofacitinib)

For **Enbrel** (etanercept) requests:

Select if the patient has had inadequate response or inability to tolerate the following [paid claims or submission of medical records (e.g., chart notes) are required]:

- ❑ **Cimzia** (certolizumab)
- ❑ **Humira** (adalimumab)
- ❑ **Orencia SQ** (abatacept)
- ❑ **Rinvoq** (upadacitinib)
- ❑ **Simponi** (golimumab)
- ❑ **Skyrizi** (risankizumab)
- ❑ **Stelara** (ustekinumab)
- ❑ **Taltz** (ixekizumab)
- ❑ **Tremfya** (guselkumab)
- ❑ **Xeljanz/Xeljanz XR** tablets/extended-release tablets (tofacitinib)

For **Orencia SQ** (abatacept) or **Taltz** (ixekizumab) requests:

Does the patient have active psoriatic arthritis? ❑ **Yes** ❑ **No**

Select if the patient has had inadequate response or inability to tolerate the following [paid claims or submission of medical records (e.g., chart notes) are required]:

- ❑ **Cimzia** (certolizumab)
- ❑ **Humira** (adalimumab)
- ❑ **Rinvoq** (upadacitinib)
- ❑ **Simponi** (golimumab)
- ❑ **Skyrizi** (risankizumab)
- ❑ **Stelara** (ustekinumab)
- ❑ **Tremfya** (guselkumab)
- ❑ **Xeljanz/Xeljanz XR** tablets/extended-release tablets (tofacitinib)

For **Rinvoq** (Upadacitinib) or **Xeljanz/Xeljanz XR** tablets/extended-release tablets (tofacitinib) requests:

Does the patient have active psoriatic arthritis? ❑ **Yes** ❑ **No**

Has the patient had inadequate response or intolerance to one or more TNF inhibitors (e.g., Cimzia, Humira, Simponi) [paid claims or submission of medical records (e.g., chart notes) are required]? ❑ **Yes** ❑ **No**

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Reauthorization (Psoriatic Arthritis):

Select if there is documentation of positive clinical response to therapy as evidenced by the following:

- ❑ Reduction in the total active (swollen and tender) joint count from baseline
- ❑ Improvement in symptoms (e.g., pain, stiffness, pruritus, inflammation) from baseline
- ❑ Reduction in the body surface area involvement from baseline

Recurrent Pericarditis:

For **Arcalyst** (rilonacept) requests:

Is Arcalyst being used for the treatment of recurrent pericarditis as evidenced by at least 2 episodes that occur a minimum of 4 to 6 weeks apart and reduction in risk of recurrence? ❑ **Yes** ❑ **No**

Select if the patient has had inadequate response or inability to tolerate the following [submission of medical records (e.g., chart notes) is required]:

- ❑ NSAID (e.g., ibuprofen, naproxen)
- ❑ Colchicine
- ❑ Corticosteroids (e.g., prednisone)

Reauthorization (Recurrent Pericarditis):

Is there documentation of positive clinical response to therapy? ❑ **Yes** ❑ **No**

Rheumatoid Arthritis:

For **Actemra SQ** (tocilizumab) or **Orencia SQ** (abatacept) requests:

Does the patient have moderate to severe rheumatoid arthritis? ❑ **Yes** ❑ **No**

Has the patient had inadequate response or inability to tolerate one of the following disease-modifying anti-rheumatic drugs (DMARDs) at maximally indicated doses [paid claims or submission of medical records (e.g., chart notes) are required]: Methotrexate, hydroxychloroquine, leflunomide, azathioprine, sulfasalazine? ❑ **Yes** ❑ **No**

Select if the patient has had inadequate response or inability to tolerate the following [paid claims or submission of medical records (e.g., chart notes) are required]:

- ❑ **Cimzia** (certolizumab)
- ❑ **Humira** (adalimumab)
- ❑ **Rinvoq** (upadacitinib)
- ❑ **Simponi** (golimumab)
- ❑ **Xeljanz/Xeljanz XR** (tofacitinib)

For **Cimzia** (certolizumab), **Humira** (adalimumab), or **Simponi** (golimumab) requests:

Does the patient have moderate to severe rheumatoid arthritis? ❑ **Yes** ❑ **No**

Has the patient had inadequate response or inability to tolerate one of the following disease-modifying anti-rheumatic drugs (DMARDs) at maximally indicated doses [paid claims or submission of medical records (e.g., chart notes) are required]: Methotrexate, hydroxychloroquine, leflunomide, azathioprine, sulfasalazine? ❑ **Yes** ❑ **No**

For **Enbrel** (etanercept), **Kevzara** (sarilumab), **Kineret** (anakinra), or **Olumiant** (baricitinib) requests:

Does the patient have moderate to severe rheumatoid arthritis? ❑ **Yes** ❑ **No**

Has the patient had inadequate response or inability to tolerate one of the following disease-modifying anti-rheumatic drugs (DMARDs) at maximally indicated doses [paid claims or submission of medical records (e.g., chart notes) are required]: Methotrexate, hydroxychloroquine, leflunomide, azathioprine, sulfasalazine? ❑ **Yes** ❑ **No**

Select if the patient has had inadequate response or inability to tolerate the following [paid claims or submission of medical records (e.g., chart notes) are required]:

- ❑ **Actemra SQ** (tocilizumab)
- ❑ **Cimzia** (certolizumab)
- ❑ **Humira** (adalimumab)
- ❑ **Orencia SQ** (abatacept)
- ❑ **Rinvoq** (upadacitinib)
- ❑ **Simponi** (golimumab)
- ❑ **Xeljanz/Xeljanz XR** (tofacitinib)

For **Rinvoq** (upadacitinib) or **Xeljanz/Xeljanz XR** (tofacitinib) requests:

Does the patient have moderate to severe rheumatoid arthritis? ❑ **Yes** ❑ **No**

Has the patient had inadequate response or inability to tolerate one of the following disease-modifying anti-rheumatic drugs (DMARDs) at maximally indicated doses [paid claims or submission of medical records (e.g., chart notes) are required]: Methotrexate, hydroxychloroquine, leflunomide, azathioprine, sulfasalazine? ❑ **Yes** ❑ **No**

Has the patient had an inadequate response or intolerance to one or more TNF inhibitors (e.g., Cimzia, Humira, Simponi)? ❑ **Yes** ❑ **No**

Reauthorization (Rheumatoid Arthritis):

Select if there is documentation of positive clinical response to therapy as evidenced by the following:

- ❑ Reduction in the total active (swollen and tender) joint count from baseline
- ❑ Improvement in symptoms (e.g., pain, stiffness, inflammation) from baseline

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Systemic Juvenile Idiopathic Arthritis (SJIA):

For **Actemra SQ** (tocilizumab) requests:

Does the patient have active systemic juvenile idiopathic arthritis (SJIA)? ❑ **Yes** ❑ **No**

Select if the patient has had inadequate response or inability to tolerate one of the following conventional therapies at maximally indicated doses [paid claims or submission of medical records (e.g., chart notes) are required]:

- ❑ DMARDs (e.g. leflunomide, methotrexate)
- ❑ Non-steroidal anti-inflammatory drug (NSAID) (e.g., ibuprofen)
- ❑ Systemic glucocorticoid (e.g., prednisone)

Reauthorization (Systemic Juvenile Idiopathic Arthritis):

Select if there is documentation of positive clinical response to therapy as evidenced by the following:

- ❑ Reduction in the total active (swollen and tender) joint count from baseline
- ❑ Improvement in clinical features or symptoms (e.g., pain, fever, inflammation, rash, lymphadenopathy, serositis) from baseline

Systemic sclerosis-associated interstitial lung disease (SSc-ILD):

For **Actemra SQ** (tocilizumab) requests:

Was the diagnosis of SSc-ILD confirmed by a High Resolution CT scan or biopsy? ❑ **Yes** ❑ **No**

Select if the patient has had inadequate response or inability to tolerate the following [paid claims or submission of medical records (e.g., chart notes) are required]:

- ❑ Azathioprine
- ❑ Cyclophosphamide
- ❑ Mycophenolate

Reauthorization (Systemic sclerosis-associated interstitial lung disease):

Is there documentation of positive clinical response to therapy? ❑ **Yes** ❑ **No**

Ulcer of the mouth associated with Behcet's syndrome:

For **Otezla** (apremilast) requests:

Does the patient have active oral ulcers? ❑ **Yes** ❑ **No**

Has the patient had inadequate response or inability to tolerate systemic corticosteroids, topical corticosteroids, or topical sucralfate [paid claims or submission of medical records (e.g., chart notes) are required]? ❑ **Yes** ❑ **No**

Reauthorization (Ulcer of the mouth associated with Behcet's syndrome):

Select if there is documentation of positive clinical response to therapy as evidenced by the following:

- ❑ Reduction in pain from oral ulcers from baseline
- ❑ Reduction in number of oral ulcers from baseline

Ulcerative Colitis:

For **Humira** (adalimumab), **Simponi** (golimumab) or **Stelara** (ustekinumab) requests:

Does the patient have moderate to severe ulcerative colitis? ❑ **Yes** ❑ **No**

Has the patient had inadequate response or inability to tolerate one of the following medications [paid claims or submission of medical records (e.g., chart notes) are required]: Corticosteroids, azathioprine, and/or 6-mercaptopurine? ❑ **Yes** ❑ **No**

For **Rinvoq** (upadacitinib) or **Xeljanz/Xeljanz XR** tablets/extended-release tablets (tofacitinib) requests:

Does the patient have moderate to severe ulcerative colitis? ❑ **Yes** ❑ **No**

Has the patient had inadequate response or inability to tolerate one of the following medications [paid claims or submission of medical records (e.g., chart notes) are required]: Corticosteroids, azathioprine, 6-mercaptopurine? ❑ **Yes** ❑ **No**

Has the patient had inadequate response or inability to tolerate ONE or more TNF inhibitors (e.g., Humira, Simponi) [paid claims or submission of medical records (e.g., chart notes) are required]? ❑ **Yes** ❑ **No**

For **Zeposia** (ozanimod) requests:

Does the patient have moderate to severe ulcerative colitis? ❑ **Yes** ❑ **No**

Has the patient had inadequate response or inability to tolerate one of the following medications [paid claims or submission of medical records (e.g., chart notes) are required]: Corticosteroids, azathioprine, and/or 6-mercaptopurine? ❑ **Yes** ❑ **No**

Select if the patient has had inadequate response or inability to tolerate the following [paid claims or submission of medical records (e.g., chart notes) are required]:

❑ **Humira** ❑ **Rinvoq** ❑ **Simponi** ❑ **Stelara** ❑ **Xeljanz/Xeljanz XR**

Reauthorization (Ulcerative Colitis):

Select if there is documentation of positive clinical response to therapy as evidenced by the following:

- ❑ Improvement in intestinal inflammation (e.g., mucosal healing, improvement in lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline
- ❑ Reversal of high fecal output state

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Uveitis:

For **Humira** (adalimumab) requests**:**

Does the patient have non-infectious intermediate, posterior, or panuveitis [submission of medical records (e.g., chart notes, lab values) is required]? ❑ **Yes** ❑ **No**

Has the patient had inadequate response or inability to tolerate ophthalmic and oral corticosteroids [paid claims or submission of medical records (e.g., chart notes) are required]? ❑ **Yes** ❑ **No**

Reauthorization (Uveitis):

Is there documentation of positive clinical response to therapy? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.