FUTURE SCRIPTS

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

Immune Modulating Therapy Prior Authorization Request Form (Page 1 of 4)

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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)

Select the diagnosis below:

- ❑ Ankylosing spondylitis
- ❑ Crohn's disease
- ❑ Cryopyrin-associated periodic syndromes (CAPS)
- ❑ Giant cell arteritis
- ❑ Hidradenitis suppurativa
- ❑ Plaque psoriasis
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____
- ❑ Polyarticular juvenile idiopathic arthritis (PJIA)
- ❑ Psoriatic arthritis
- ❑ Rheumatoid arthritis (RA)
- ❑ Systemic juvenile idiopathic arthritis (SJIA)
- ❑ Ulcerative colitis
- ❑ Uveitis

Prescriber's Specialty:

Select if the requested medication is recommended by one of the following specialists:

- ❑ Dermatologist
- ❑ Gastroenterologist
- ❑ Ophthalmologist
- ❑ Rheumatologist
- ❑ Other: _____

Ankylosing Spondylitis:

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

Has the patient had inadequate response or inability to tolerate one of the following disease-modifying anti-rheumatic drugs (DMARDs): methotrexate, hydroxychloroquine, leflunomide, azathioprine, sulfasalazine? ❑ **Yes** ❑ **No**

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

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

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

Select if the patient has inadequate response, inability to tolerate, or documentation demonstrating a trial may be inappropriate of the following:

❑ **Cimzia** (certolizumab) ❑ **Humira** (adalimumab) ❑ **Simponi** (golimumab)

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

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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:

- ❑ 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)

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

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)? ❑ **Yes** ❑ **No**

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

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

For **Kineret** (anakinra) requests:

Does the patient have a diagnosis of neonatal onset multisystem inflammatory disease (NOMID)? ❑ **Yes** ❑ **No**

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

Giant Cell Arteritis:

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

Has the patient had inadequate response or inability to tolerate a glucocorticoid (i.e., prednisone)? ❑ **Yes** ❑ **No**

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

Hidradenitis Suppurativa:

For **Humira** (adalimumab) requests:

Does the patient have moderate to severe hidradenitis suppurativa (i.e., Hurley stage II or III)? ❑ **Yes** ❑ **No**

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

Plaque Psoriasis:

For **Cimzia** (certolizumab), **Humira** (adalimumab), **Otezla** (apremilast), **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: topical calcipotriene-containing products, topical anthralin, topical steroids, topical immune modulators (Elidel, Protopic), and/or topical retinoids? ❑ **Yes** ❑ **No**

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

For **Cosentyx** (secukinumab), **Enbrel** (etanercept), or **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: topical calcipotriene-containing products, topical anthralin, topical steroids, topical immune modulators (Elidel, Protopic), and/or topical retinoids? ❑ **Yes** ❑ **No**

Select if the patient has inadequate response, inability to tolerate, or documentation demonstrating a trial may be inappropriate of the following:

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

For **Otrexup** (methotrexate injection) or **Rasuvo** (methotrexate injection) requests:

Does the patient have severe psoriasis? ❑ **Yes** ❑ **No**

Has the patient had inadequate response to ALL other standard therapy (e.g., oral methotrexate, all topical therapy modalities, phototherapy, etc.)? ❑ **Yes** ❑ **No**

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Polyarticular Juvenile Idiopathic Arthritis (PJIA):

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): methotrexate, hydroxychloroquine, leflunomide, azathioprine, sulfasalazine? ❑ **Yes** ❑ **No**

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

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

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

Has the patient had inadequate response, inability to tolerate, or documentation demonstrating a trial may be inappropriate of **Humira** (adalimumab)? ❑ **Yes** ❑ **No**

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

For **Otrexup** (methotrexate injection) or **Rasuvo** (methotrexate injection) requests:

Does the patient have inadequate response or inability to tolerate oral methotrexate? ❑ **Yes** ❑ **No**

Psoriatic Arthritis:

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

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

Has the patient had inadequate response or inability to tolerate one of the following disease-modifying anti-rheumatic drugs (DMARDs): methotrexate, hydroxychloroquine, leflunomide, azathioprine, sulfasalazine? ❑ **Yes** ❑ **No**

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

For **Cosentyx** (secukinumab), **Enbrel** (etanercept), **Orencia SQ** (abatacept), **Taltz** (ixekizumab), or **Xeljanz/Xeljanz XR** (tofacitinib) requests:

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

Select if the patient has inadequate response, inability to tolerate, or documentation demonstrating a trial may be inappropriate of the following:

❑ **Cimzia** (certolizumab) ❑ **Humira** (adalimumab) ❑ **Simponi** (golimumab) ❑ **Stelara** (ustekinumab)

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

For **Otrexup** (methotrexate injection) or **Rasuvo** (methotrexate injection) requests:

Has the patient had inadequate response or inability to tolerate oral methotrexate? ❑ **Yes** ❑ **No**

Rheumatoid Arthritis:

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): methotrexate, hydroxychloroquine, leflunomide, azathioprine, sulfasalazine? ❑ **Yes** ❑ **No**

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

For **Actemra SQ** (tocilizumab), **Enbrel** (etanercept), **Kevzara** (sarilumab), **Kineret** (anakinra), **Olumiant** (baricitinib), or **Orencia SQ** (abatacept) requests:

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

Select if the patient has inadequate response, inability to tolerate, or documentation demonstrating a trial may be inappropriate of the following:

❑ **Cimzia** (certolizumab) ❑ **Humira** (adalimumab) ❑ **Simponi** (golimumab)

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

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For **Xeljanz/Xeljanz XR** (tofacitinib) requests:

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

Does the patient have inadequate response or inability to tolerate methotrexate? ❑ **Yes** ❑ **No**

Select if the patient has inadequate response, inability to tolerate, or documentation demonstrating a trial may be inappropriate of the following:

❑ **Cimzia** (certolizumab) ❑ **Humira** (adalimumab) ❑ **Simponi** (golimumab)

Select if the patient will be using the requested medication concurrently with the following:

❑ A biologic DMARD (i.e., tumor necrosis factor antagonists)

❑ A potent immunosuppressant (i.e., azathioprine, cyclosporine)

For **Otrexup** (methotrexate injection) or **Rasuvo** (methotrexate injection) requests:

Does the patient have severe, active rheumatoid arthritis? ❑ **Yes** ❑ **No**

Does the patient have inadequate response or inability to tolerate oral methotrexate? ❑ **Yes** ❑ **No**

Systemic Juvenile Idiopathic Arthritis (SJIA):

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

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

Ulcerative Colitis:

For **Humira** (adalimumab) or **Simponi** (golimumab) 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: corticosteroids, azathioprine, 6-mercaptopurine, and/or aminosalicylates? ❑ **Yes** ❑ **No**

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

For **Xeljanz/Xeljanz XR** (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: corticosteroids, azathioprine, 6-mercaptopurine? ❑ **Yes** ❑ **No**

Has the patient had inadequate response or inability to tolerate Humira and Simponi? ❑ **Yes** ❑ **No**

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

Uveitis:

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

Does the patient have non-infectious intermediate, posterior, or panuveitis? ❑ **Yes** ❑ **No**

Has the patient had inadequate response or inability to tolerate ophthalmic and oral corticosteroids? ❑ **Yes** ❑ **No**

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? ❑ **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.