iowa total care   Iowa Health Link **Iowa HHS**   Hawki **Iowa HHS**

Fax Completed Form To
1.833.404.2392
Prescriber Help Desk
1.833.587.2012
Online
covermymeds.com/main/
prior-authorization-forms/

Request for Prior Authorization
BIOLOGICALS FOR ARTHRITIS
(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB

Patient address

Provider NPI	Prescriber name	Phone

Prescriber address	Fax

Pharmacy name	Address	Phone

Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.

Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for biologicals used for arthritis. Request must adhere to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations. Payment for non-preferred biologicals for arthritis will be considered only for cases in which there is documentation of previous trials and therapy failures with two preferred biological agents.

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Preferred
- ☐ Adalimumab-aacf
- ☐ Adalimumab-adbm
- ☐ Adalimumab-fkjp
- ☐ Enbrel
- ☐ Humira
- ☐ Kineret
- ☐ Orencia ClickJect
- ☐ Pyzchiva

- ☐ Simlandi
- ☐ Simponi
- ☐ Skyrizi Auto-Injector
- ☐ Skyrizi Cartridge
- ☐ Skyrizi Prefilled Syringe
- ☐ Taltz (step through one preferred TNF)
- ☐ Tremfya
- ☐ Tyenne Auto-Injector
- ☐ Tyenne Prefilled Syringe
- ☐ Yusimry

Non-Preferred
- ☐ Actemra
- ☐ Bimzelx
- ☐ Cimzia (prefilled syringe)
- ☐ Cosentyx
- ☐ Ilaris
- ☐ Kevzara
- ☐ Orencia Prefilled Syringe
- ☐ Stelara
- ☐ Other Humira Biosimilar:_____
- ☐ Other Stelara Biosimilar:_____

Strength	**Dosage Instructions**	**Quantity**	**Days Supply**
_____	_____	_____	_____

☐ **Rheumatoid arthritis (RA); with**
Documentation of a trial and inadequate response, at a maximally tolerated dose, with methotrexate (hydroxychloroquine, sulfasalazine, or leflunomide may be used if methotrexate is contraindicated).

Drug Name & Dose:_____ Trial dates: _____
Failure reason: _____

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☐ **Psoriatic arthritis, moderate to severe; with**
Documentation of a trial and inadequate response, at a maximally tolerated dose, with methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated).

Drug Name &Dose:_____ Trial dates: _____
Failure reason: _____

☐ **Juvenile idiopathic arthritis with oligoarthritis; with**

Documentation of a trial and inadequate response to intraarticular glucocorticoid injections and methotrexate at a maximally tolerated dose (leflunomide or sulfasalazine may be used if methotrexate is contraindicated).

Intraarticular Glucocorticoid Injections: Drug Name & Dose:_____ Trial dates: _____
Failure reason: _____

Plus methotrexate or preferred oral DMARD trial: Drug Name & Dose:_____
Trial dates:_____ Failure reason: _____

☐ **Polyarticular juvenile idiopathic arthritis (pJIA), moderate to severe; with**

Documentation of a trial and inadequate response, at a maximally tolerated dose, with methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated).

Drug Name &Dose:_____ Trial dates: _____
Failure reason: _____

☐ **Systemic juvenile idiopathic arthritis (sJIA)**

Reason for use of Non-Preferred drug requiring prior approval:_____
_____

Other medical conditions to consider: _____
Attach lab results and other documentation as necessary.

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary, by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.*