



**Request for Prior Authorization**  
**BIOLOGICALS FOR AXIAL SPONDYLOARTHRITIS**  
 (PLEASE PRINT – ACCURACY IS IMPORTANT)

**Screening for Latent TB infection:** Date: \_\_\_\_\_ Results: \_\_\_\_\_

**NSAID Trial #1** Name/Dose: \_\_\_\_\_ Trial start date: \_\_\_\_\_ Trial end date: \_\_\_\_\_

Reason for Failure: \_\_\_\_\_

**NSAID Trial #2** Name/Dose: \_\_\_\_\_ Trial start date: \_\_\_\_\_ Trial end date: \_\_\_\_\_

Reason for Failure: \_\_\_\_\_

**DMARD Trial** (for peripheral arthritis diagnosis) Name/Dose: \_\_\_\_\_

Trial start date: \_\_\_\_\_ Trial end date: \_\_\_\_\_ Reason for Failure: \_\_\_\_\_

**Requests for TNF Inhibitors:**

**Has patient received treatment for solid malignancies, nonmelanoma skin cancer, or lymphoproliferative malignancy within last 5 years of starting or resuming treatment with a biologic agent?**  Yes  No

**Does patient have a diagnosis of NYHA class III or IV CHF diagnosis with ejection fraction of 50% or less?**  Yes  No

**Requests for Interleukins:**

**Will medication be given concurrently with live vaccines?**  Yes  No

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

Other medical conditions to consider: \_\_\_\_\_

Possible drug interactions/conflicting drug therapies: \_\_\_\_\_

**Attach lab results and other documentation as necessary.**

Prescriber signature (Must match prescriber listed above.)	Date of submission
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**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 Human Services, that the member continues to be eligible for Medicaid.