







FAX Completed Form To 1.833.404.2392

Pharmacy Help Desk 1.800.460.8988

Prescriber Help Desk 1.833.587.2012

Request for Prior Authorization BIOLOGICALS FOR HIDRADENITIS SUPPURATIVA

(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 	
Patients initiating therapy with a biological agent must 1) Be screened for hepatitis B and C, patients with active hepatitis B will not be considered for coverage; and 2) Have not been treated for solid malignancies, nonmelanoma skin cancer, or lymphoproliferative malignancy within the last 5 years of starting or resuming treatment with a biological agent; and 3) Not have a diagnosis of congestive heart failure (CHF) that is New York Heart Association (NYHA) class III or IV and with an ejection fraction of 50% or less; and 4) Be screened for latent TB infection. Patients with latent TB will only be considered after one month of TB treatment and patients with active TB will only be considered upon completion of TB treatment. Payment will be considered under the following conditions: 1) Patient has a diagnosis of moderate to severe HS with Hurley Stage II or III disease; and 2) Patient is 18 years of age or older; and 3) Patient has at least three (3) abscesses or inflammatory nodules; and 4) Patient has documentation of adequate trials and therapy failures with the following: a) Daily treatment with topical clindamycin; b) Oral clindamycin plus rifampin; c) Maintenance therapy with tetracyclines (doxycycline or minocycline). If criteria for coverage are met, initial requests will be given for 3 months. Additional authorizations will be considered upon documentation of clinical response to therapy. Clinical response is defined as at least a 50% reduction in total abscess and inflammatory nodule count with no increase in abscess count and no increase in draining fistula count from initiation of therapy. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.			
Preferred			
☐ Humira			
Strength	Dosage Instructions	Quantity	Days Supply
Screening for Hepatitis B: Date	e:	Active Disease: Y	es 🗌 No
Screening for Hepatitis C: Date	e:	Active Disease: Y	es 🗌 No
Screening for Latent TB infection	n: Date:	Results:	
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?			
Does patient have a diagnosis of	f NYHA class III or IV CHF dia	agnosis with ejection fra	ction of 50% or less:

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Request for Prior Authorization-Continued BIOLOGICALS FOR HIDRADENITIS SUPPURATIVA

(PLEASE PRINT – ACCURACY IS IMPORTANT) Diagnosis: ☐ Hidradenitis Suppurativa: Hurley Stage: ☐ I ☐ II ☐ III Does patient have at least three (3) absesses or inflammatory nodules? □ No Yes: Abscess/Nodule count: Date obtained: Topical Clindamycin Trial Name/Dose: Trial dates: Reason for failure: Oral Clindamycin Plus Rifampin Trial: Clindamycin: Dose:_____ Trial dates: Reason for failure: Rifampin: Dose: Trial dates: Reason for failure: **Maintenance Tetracycline Trial (doxycycline or minocycline):** Name/Dose: Reason for failure: Renewals **Document response to therapy:** Yes Has patient had an increase in draining fistula count since initiation of therapy? 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 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.

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