





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	
Pharmacy NPI	Pharmacy fax NDC		
arthritis will be considered only with two preferred biological ag been screened for latent TB in treatment and patients with actihas been screened for hepatitis antigen positive > 6 months) mitreatment. In addition to the above: Requests for TNF Inhibitors: 1) Flymphoproliferative malignancy and 2) Patient does not have a d (NYHA) class III or IV and with an Requests for Interleukins: Medic	ion, dosing, and contraindications. Payment for cases in which there is documentation of ents. Payment will be considered under the forection, patients with latent TB will only be ve TB will only be considered upon complete B and C. Patients with evidence of active her ust have documentation they are receiving or resuming agnosis of congestive heart failure (CHF) that is ejection fraction of 50% or less. ation will not be given concurrently with live will be a concurrently with live will be	previous trials and therapy failures ollowing conditions: 1) Patient has considered after one month of TE on of TB treatment; and 2) Patient patitis B infection (hepatitis surface or have received effective antiviral cies, nonmelanoma skin cancer, or treatment with a biological agent; is New York Heart Association accines.	
Enbrel Humira Kineret Taltz (after step through one preferred TNF)	Actemra Ilar Cimzia (prefilled syringe) Ke	is	
Strength	Dosage Instructions Quantity Da	ys Supply	
Screening for Hepatitis C: Da	Active Disease: Active Disease	′es □ No	
	tion: Date: Results:		
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			

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Does patient have a diagnosis of NYHA class III or IV CHF diagnos less? Yes No Requests for Interleukins:	is with ejection fraction of 50% or
Will medication be given concurrently with live vaccines?	s 🗌 No
Rheumatoid arthritis (RA); with Documentation of a trial and inadequate response, at a maximally tolera (hydroxychloroquine, sulfasalazine, or leflunomide may be used if methods.	
Drug Name & Dose:Trial dates	::
Failure reason:	
☐ Psoriatic arthritis, moderate to severe; with Documentation of a trial and inadequate response, at a maximally tolera (leflunomide or sulfasalazine may be used if methotrexate is contraindic	
Drug Name &Dose:Trial dates: Failure reason:	
Juvenile idiopathic arthritis, moderate to severe; with Documentation of a trial and inadequate response to intraarticular gluco a maximally tolerated dose (leflunomide or sulfasalazine may be used if	
Intraarticular Glucocorticoid Injections: Drug Name & Dose:	Trial dates:
Failure reason:	
Plus methotrexate or preferred oral DMARD trial: Drug Name & Dos Trial dates: Failure reason:	
Reason for use of Non-Preferred drug requiring prior approval:	
Other medical conditions to consider: 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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