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 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

Prior authorization (PA) is required for biologicals FDA approved or compendia indicated for the treatment of Hidradenitis Suppurativa (HS). Payment for non-preferred biologic agents will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred biologic agent. 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) Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in special populations. 2) Patient has a diagnosis of moderate to severe HS with Hurley Stage II or III disease; 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 a preferred tetracycline. 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:_____ Active Disease: ☐ Yes ☐ No

Screening for Hepatitis C: Date:_____ Active Disease: ☐ Yes ☐ No

Screening for Latent TB infection: 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? ☐ Yes ☐ No

Does patient have a diagnosis of NYHA class III or IV CHF diagnosis with ejection fraction of 50% or less:

☐ Yes ☐ No

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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

☐ Other:_____

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 Preferred Tetracycline Trial:

Name/Dose:_____ Trial dates:_____

Reason for failure:_____

<u>Renewals</u>

Document response to therapy:

Abscess/Nodule Count: ☐ Increase ☐ Decrease (provide count):_____ Date obtained:_____

Has patient had an increase in draining fistula count since initiation of therapy? ☐ No ☐ Yes

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.*