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
Remibrutinib (Rhapsido)

(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 remibrutinib (Rhapsido). Payment for non-preferred agents will be considered when there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered when patient has an FDA approved or compendia indication for the requested drug 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 specific populations; and

2. Patient has a diagnosis of chronic spontaneous urticaria (CSU) with no known cause; and

3. Patient has documentation of an adequate trial and therapy failure with a preferred second generation H1 receptor antihistamine for at least 2 weeks.
If criteria for coverage are met, initial authorization will be given for 12 months to assess response to treatment. Requests for continuation of therapy will require documentation of a positive response to therapy.

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

Preferred

☐ Rhapsido

Strength	Usage Instructions	Quantity	Day's Supply

Diagnosis: _____

H1 receptor antihistamine trial:

Name/dose: _____ Trial dates: _____

Failure reason/medical contraindication: _____

Renewal Requests

Document positive clinical response to therapy: _____

_____

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 Health and Human Services, that the member continues to be eligible for Medicaid.*

(Rev. 6/26)