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 AXIAL SPONDYLOARTHRITIS

(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 is required for biologicals used for axial spondyloarthritis conditions. Payment will be considered under the following conditions: 1) Patient has a diagnosis of ankylosing spondylitis (AS) or nonradiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation; and 2) The requested dose does not exceed the maximum FDA labeled or compendia recommended dose for the submitted diagnosis; and 3) Patient has been screened for hepatitis B and C, patients with active hepatitis B will not be considered for coverage; and 4) Patient has been 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; and 5) Patient has documentation of an inadequate response to at least two preferred non-steroidal anti-inflammatories (NSAIDs) at maximum therapeutic doses, unless there are documented adverse responses or contraindications to NSAID use. These trials should be at least one month in duration: and 6) Patients with symptoms of peripheral arthritis must also have failed a 30-day treatment trial with at least one conventional disease modifying antirheumatic drug (DMARD), unless there is a documented adverse response or contraindication to DMARD use. DMARDs include sulfasalazine and methotrexate; and 7) Requests for non-preferred biologicals for axial spondyloarthritis conditions will be considered only for cases in which there is documentation of previous trials and therapy failures with two preferred biological agents that are FDA approved or compendia indicated for the submitted diagnosis, when applicable.
In addition to the above:
Requests for TNF Inhibitors: 1) Patient has 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 2) Patient does 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.
Requests for Interleukins: Medication will not be given concurrently with live vaccines.
The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Preferred
☐ Enbrel ☐ Taltz (after step through one preferred TNF)
☐ Humira

Non-Preferred
☐ Cimzia ☐ Simponi
☐ Cosentyx

Strength	Dosage Instructions	Quantity	Days Supply

Diagnosis: _____

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

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

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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

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.*