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 INFLAMMATORY BOWEL DISEASE

(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 inflammatory bowel disease. Request must adhere to all FDA approved labeling. Payment for non-preferred biologicals for inflammatory bowel disease will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered under the following conditions: 1) Patient has been screened for hepatitis B and C, patients with active hepatitis B will not be considered for coverage; and 2) 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.
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
- ☐ Humira
- ☐ Humira Starter Kit
- ☐ Simponi

Non-Preferred
- ☐ Adalimumab adaz
- ☐ Adalimumab fkjp
- ☐ Cimzia (prefilled syringe)
- ☐ Skyrizi
- ☐ Stelara

☐ Humira Biosimilar: Drug Name________________________

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: ________________________________

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 diagnosis with ejection fraction of 50% or less?
☐ Yes ☐ No

Requests for Interleukins:

Will medication be given concurrently with live vaccines? ☐ Yes ☐ No

☐ **Crohn's Disease – Payment will be considered following an inadequate response to two preferred conventional therapies including aminosalicylates (mesalamine, sulfasalazine), azathioprine/6-mercaptopurine, and/or methotrexate.**

Trial Drug Name/Dose: ________________________ Trial dates:______________

Reason for failure: ____

Trial Drug Name/Dose: ________________________ Trial dates:______________

Reason for failure: ____

Reason for use of Non-Preferred drug requiring prior approval: ______________________

☐ **Ulcerative colitis (moderate to severe) – Payment will be considered following an inadequate response to two preferred conventional therapies including aminosalicylates and azathioprine/6-mercaptopurine.**

Trial Drug Name/Dose: ________________________ Trial dates:______________

Reason for failure:____

Trial Drug Name/Dose: ________________________ Trial dates:______________

Reason for failure: ____

Reason for use of Non-Preferred drug requiring prior approval: ______________________

Possible drug interactions/conflicting drug therapies/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 Health and Human Services, that the member continues to be eligible for Medicaid.*