





Request for Prior Authorization BIOLOGICALS FOR AXIAL SPONDYLOARTHRITIS

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Fax Completed Form To 1.833.404.2392 Prescriber Help Desk

Prescriber Help Desk 1.833.587.2012

Online

covermymeds.com/main/ prior-authorization-forms/

IA Medicaid M	lember ID #	Patient name DOB							
Patient addres	ss								
Provider NPI		Prescriber name	Prescriber name		Phone				
Prescriber add	dress			Fax					
Pharmacy name		Address	Address		Phone				
Prescriber mu	ıst complete all inform	nation above. It must be legible	e correct and c	omplete or fo	rm will be	returned			
Pharmacy NP	Prescriber must complete all information above. It must be legible, correct, and complete or for Pharmacy NPI Pharmacy fax NDC								
	<u> </u>								
Prior authorization (PA) is required for biologicals used for axial spondyloarthritis conditions. Request must adhere to all approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations. Payment will be considered under the following conditions: 1. Patient has a diagnosis of ankylosing spondylitis (AS) or nonradiographic axial spondyloarthritis (nr-axSpA)									
	e signs of inflamma		r nonradiograp	mic axiai sp	ondyloai	runnus (nr	-axo _l	JA)	
inflammatori	es (NSAIDs) at max	an inadequate response to imum therapeutic doses, u These trials should be at l	nless there are	documente	ed advers		ses o	r	
conventiona	l disease modifying	eripheral arthritis must also antirheumatic drug (DMAF . DMARDs include sulfasala	RD), unless the	re is a docu	mented a				
in which the	re is documentation	oiologicals for axial spondy n of previous trials and ther a indicated for the submitte	apy failures wi	th two prefe	rred biol				
	trials may be overi contraindicated.	ridden when documented e	vidence is pro	vided that u	se of the	se agents	wou	ld	
Preferred □ Enbrel □ Humira □ Simponi	☐ Taltz (after step th	ough one preferred TNF)				□ Cimzia □ Cosentyx			
			☐ Humira Biosimilar: Drug Name						
	Of ways and la	Doorna Instruction	0	De C					
	Strength	Dosage Instructions	Quantity	Days Su	ippiy				
					_				

Rev. 10/24 Page 1 of 2

Diagnosis: _







Request for Prior Authorization BIOLOGICALS FOR AXIAL SPONDYLOARTHRITIS

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Fax Completed Form To 1.833.404.2392 Prescriber Help Desk 1.833.587.2012

Online covermymeds.com/main/prior-authorization-forms/

NSAID Trial #1 Name/Dose:	_Trial start date:	al start date:Trial end date:							
Reason for Failure:									
NSAID Trial #2 Name/Dose:Reason for Failure:		Trial end date:							
DMARD Trial (for peripheral arthritis diagnosis) Name/Dose:									
Frial start date: Trial end date: Reason for Failure:									
Medical or contraindication reason to override trial requirements:									
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 sub	mission							

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. 10/24 Page 2 of 2