



Fax Completed Form To

1.833.404.2392

Prescriber Help Desk

1.833.587.2012

Online

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

Request for Prior Authorization

BIOLOGICALS FOR AXIAL

SPONDYLOARTHRITIS

(PLEASE PRINT – ACCURACY IS IMPORTANT)

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: _____

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 submission
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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.