



Fax Completed Form To  
1.833.404.2392

Prescriber Help Desk  
1.833.587.2012

Online

[covermy meds.com/main/prior-authorization-forms/](http://covermy meds.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 (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) with objective signs of inflammation; and
2. 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
3. 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
4. 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.

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

**Preferred**

- Adalimumab-aacf
- Adalimumab-adbm
- Adalimumab-fkjp
- Amjevita 40mg/0.4mL
- Amjevita 80mg/0.8mL
- Enbrel
- Humira
- Simponi
- Simlandi
- Taltz (step through one preferred TNF)
- Yusimry

**Non-Preferred**

- Cimzia
- Cosentyx
- Other Humira Biosimilar: \_\_\_\_\_

Strength	Dosage Instructions	Quantity	Days Supply
_____	_____	_____	_____

**Diagnosis:** \_\_\_\_\_

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**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.