iowa total care | Iowa Health Link Iowa HHS | Hawki Iowa HHS

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 HIDRADENITIS SUPPURATIVA

(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 FDA approved or compendia indicated for the treatment of Hidradenitis Suppurativa (HS). Payment for non-preferred biologic agents will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred biologic agent.

Payment will be considered under the following conditions: 1) Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in special populations. 2) Patient has a diagnosis of moderate to severe HS with Hurley Stage II or III disease; and 3) Patient has at least three (3) abscesses or inflammatory nodules; and 4) Patient has documentation of adequate trials and therapy failures with the following: a) Daily treatment with topical clindamycin; b) Oral clindamycin plus rifampin; c) Maintenance therapy with a preferred tetracycline. If criteria for coverage are met, initial requests will be given for 4 months. Additional authorizations will be considered upon documentation of clinical response to therapy. Clinical response is defined as at least a 50% reduction in total abscess and inflammatory nodule count with no increase in abscess count and no increase in draining fistula count from initiation of therapy. 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
- ☐ Humira
- ☐ Simlandi
- ☐ Yusimry

Non-Preferred
- ☐ Bimzelx
- ☐ Cosentyx
- ☐ Other Humira Biosimilar: _____

Strength	Dosage Instructions	Quantity	Days Supply
_____	_____	_____	_____

Diagnosis:

☐ Hidradenitis Suppurativa: Hurley Stage ☐ I ☐ II ☐ III

☐ Other:_____

Does patient have at least three (3) absesses or inflammatory nodules?

☐ No ☐ Yes: Abscess/Nodule count:_____ Date obtained:_____

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Topical Clindamycin Trial Name/Dose:_____ Trial dates:_____
Reason for failure:_____

Oral Clindamycin Plus Rifampin Trial:

Clindamycin: Dose:_____ Trial dates:_____
Reason for failure:_____

Rifampin: Dose:_____ Trial dates:_____
Reason for failure:_____

Maintenance Preferred Tetracycline Trial:

Name/Dose:_____ Trial dates:_____
Reason for failure:_____

Renewals

Document response to therapy:

Abscess/Nodule Count: ☐ Increase ☐ Decrease (provide count): _____ Date obtained: _____

Has patient had an increase in draining fistula count since initiation of therapy? ☐ No ☐ Yes

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 Health and Human Services, that the member continues to be eligible for Medicaid.*