Please complete ALL information below and fax your request to 1-888-671-5285

Immune Modulating Therapy Prior Authorization Request Form (Page 1 of 6)

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Ankylosing spondylitis
- ❑ Crohn's disease
- ❑ Cryopyrin-associated periodic syndromes (CAPS)
- ❑ Deficiency of Interleukin-1 Receptor Antagonist (DIRA)
- ❑ Giant cell arteritis
- ❑ Hidradenitis suppurativa
- ❑ Non-radiographic axial spondyloarthritis (nr-axSpA)
- ❑ Plaque psoriasis
- ❑ Polyarticular juvenile idiopathic arthritis (PJIA)
- ❑ Psoriatic arthritis
- ❑ Recurrent Pericarditis
- ❑ Rheumatoid arthritis (RA)
- ❑ Systemic juvenile idiopathic arthritis (SJIA)
- ❑ Systemic sclerosis-associated interstitial lung disease (SSc-ILD)
- ❑ Ulcer of the mouth associated with Behcet's syndrome
- ❑ Ulcerative colitis
- ❑ Uveitis
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Prescriber's Specialty:

Select if the requested medication is recommended by one of the following specialists:

❑ Dermatologist ❑ Ophthalmologist ❑ Other: _____

❑ Gastroenterologist ❑ Rheumatologist

Ankylosing Spondylitis:

For **Cimzia** (certolizumab), **Humira** (adalimumab), or **Simponi** (golimumab) requests:

Has the patient had inadequate response or inability to tolerate two NSAIDs? ❑ **Yes** ❑ **No**

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? ❑ **Yes** ❑ **No**

For **Cosentyx** (secukinumab) or **Enbrel** (etanercept) requests:

Does the patient have active disease? ❑ **Yes** ❑ **No**

Select if the patient has had inadequate response or inability to tolerate the following:

❑ **Cimzia** (certolizumab) ❑ **Humira** (adalimumab) ❑ **Simponi** (golimumab) ❑ **Taltz** (ixekizumab)

Is this request for continuation of therapy with the requested product? ❑ **Yes** ❑ **No**

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? ❑ **Yes** ❑ **No**

For **Taltz** (ixekizumab) requests:

Does the patient have active disease? ❑ **Yes** ❑ **No**

Select if the patient has had inadequate response or inability to tolerate the following:

❑ **Cimzia** (certolizumab) ❑ **Humira** (adalimumab) ❑ **Simponi** (golimumab)

Is this request for continuation of therapy with the requested product? ❑ **Yes** ❑ **No**

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? ❑ **Yes** ❑ **No**

Crohn's Disease:

For **Cimzia** (certolizumab), **Humira** (adalimumab), or **Stelara** (ustekinumab) requests:

Does the patient have moderate to severe Crohn's disease? ❑ **Yes** ❑ **No**

Select if the patient has had inadequate response or inability to tolerate one drug from any of the following groups:

- ❑ Aminosalicylates: mesalamine (Asacol, Canasa, Pentasa, Rowasa), sulfasalazine
- ❑ Antibiotics: levofloxacin, metronidazole
- ❑ Corticosteroids: budesonide (Entocort EC), hydrocortisone, methylprednisolone, prednisone
- ❑ Immunomodulators: 6-mercaptopurine, azathioprine, cyclosporine, methotrexate, tacrolimus (Prograf)

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? ❑ **Yes** ❑ **No**

Cryopyrin-Associated Periodic Syndromes (CAPS):

For **Arcalyst** (rilonacept) requests:

Does the patient have a diagnosis of cryopyrin-associated periodic syndromes (CAPS), including familial cold auto-inflammatory syndrome (FCAS) and/or Muckle-Wells syndrome (MWS)? ❑ **Yes** ❑ **No**

Was Arcalyst prescribed by or in consultation with an immunologist, allergist, dermatologist, rheumatologist, neurologist or other medical specialist? ❑ **Yes** ❑ **No**

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? ❑ **Yes** ❑ **No**

For **Kineret** (anakinra) requests:

Does the patient have a diagnosis of neonatal onset multisystem inflammatory disease (NOMID)? ❑ **Yes** ❑ **No**

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? ❑ **Yes** ❑ **No**

Deficiency of Interleukin-1 Receptor Antagonist (DIRA):

For **Arcalyst** (rilonacept) requests:

Is Arcalyst being used for the maintenance of remission of Deficiency of Interleukin-1 Receptor Antagonist (DIRA)? ❑ **Yes** ❑ **No**

Does the patient weigh at least 10kg? ❑ **Yes** ❑ **No**

Was Arcalyst prescribed by or in consultation with a rheumatologist or pediatric specialist? ❑ **Yes** ❑ **No**

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? ❑ **Yes** ❑ **No**

For **Kineret** (anakinra) requests:

Was Kineret prescribed by or in consultation with a rheumatologist or pediatric specialist? ❑ **Yes** ❑ **No**

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? ❑ **Yes** ❑ **No**

Giant Cell Arteritis:

For **Actemra SQ** (tocilizumab) requests:

Has the patient had inadequate response or inability to tolerate a glucocorticoid (i.e., prednisone)? ❑ **Yes** ❑ **No**

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? ❑ **Yes** ❑ **No**

Hidradenitis Suppurativa:

For **Humira** (adalimumab) requests:

Does the patient have moderate to severe hidradenitis suppurativa (i.e., Hurley stage II or III)? ❑ **Yes** ❑ **No**

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? ❑ **Yes** ❑ **No**

Non-radiographic Axial Spondyloarthritis (nr-axSpA):

For **Cimzia** (certolizumab) requests:

Does the patient have active non-radiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation? ❑ **Yes** ❑ **No**

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? ❑ **Yes** ❑ **No**

Continued on next page

Non-radiographic Axial Spondyloarthritis (nr-axSpA):

For **Cosentyx** (secukinumab) requests:

Does the patient have active non-radiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation? ❑ **Yes** ❑ **No**

Has the patient had an inadequate response or inability to tolerate Cimzia (certolizumab) AND Taltz (ixekizumab)? ❑ **Yes** ❑ **No**

Is this request for continuation of therapy with the requested product? ❑ **Yes** ❑ **No**

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? ❑ **Yes** ❑ **No**

For **Taltz** (ixekizumab) requests:

Does the patient have active non-radiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation? ❑ **Yes** ❑ **No**

Has the patient had an inadequate response or inability to tolerate Cimzia (certolizumab)? ❑ **Yes** ❑ **No**

Is this request for continuation of therapy with the requested product? ❑ **Yes** ❑ **No**

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? ❑ **Yes** ❑ **No**

Plaque Psoriasis:

For **Cimzia** (certolizumab), **Humira** (adalimumab), **Otezla** (apremilast), **Skyrizi** (risankizumab), **Stelara** (ustekinumab), or **Tremfya** (guselkumab) requests:

Does the patient have moderate to severe chronic plaque psoriasis? ❑ **Yes** ❑ **No**

Has the patient had inadequate response or inability to tolerate one of the following: Topical calcipotriene-containing products, topical anthralin, topical steroids, topical immune modulators (Elidel, Protopic), and/or topical retinoids? ❑ **Yes** ❑ **No**

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? ❑ **Yes** ❑ **No**

For **Cosentyx** (secukinumab) or **Enbrel** (etanercept) requests:

Does the patient have moderate to severe chronic plaque psoriasis? ❑ **Yes** ❑ **No**

Has the patient had inadequate response or inability to tolerate one of the following: Topical calcipotriene-containing products, topical anthralin, topical steroids, topical immune modulators (Elidel, Protopic), and/or topical retinoids? ❑ **Yes** ❑ **No**

Select if the patient has had inadequate response or inability to tolerate the following:

❑ **Cimzia** (certolizumab) ❑ **Humira** (adalimumab) ❑ **Skyrizi** (risankizumab)

❑ **Stelara** (ustekinumab) ❑ **Taltz** (ixekizumab) ❑ **Tremfya** (guselkumab)

Is this request for continuation of therapy with the requested product? ❑ **Yes** ❑ **No**

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? ❑ **Yes** ❑ **No**

For **Siliq** (brodalumab) requests:

Does the patient have moderate to severe chronic plaque psoriasis? ❑ **Yes** ❑ **No**

Has the patient had inadequate response or inability to tolerate one of the following: Topical calcipotriene-containing products, topical anthralin, topical steroids, topical immune modulators (Elidel, Protopic), and/or topical retinoids? ❑ **Yes** ❑ **No**

Select if the patient has had inadequate response or inability to tolerate the following:

❑ **Cimzia** (certolizumab) ❑ **Humira** (adalimumab) ❑ **Skyrizi** (risankizumab)

❑ **Stelara** (ustekinumab) ❑ **Taltz** (ixekizumab) ❑ **Tremfya** (guselkumab)

Is this request for continuation of therapy with the requested product? ❑ **Yes** ❑ **No**

Has the patient been evaluated for depression and suicidal ideations using the PHQ-9? ❑ **Yes** ❑ **No**

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? ❑ **Yes** ❑ **No**

Reauthorization for Siliq:

Has the patient had positive response to therapy with Siliq (brodalumab)? ❑ **Yes** ❑ **No**

Has the patient been evaluated for depression and suicidal ideations using the PHQ-9? ❑ **Yes** ❑ **No**

For **Taltz** (ixekizumab) requests:

Does the patient have moderate to severe chronic plaque psoriasis? ❑ **Yes** ❑ **No**

Has the patient had inadequate response or inability to tolerate one of the following: Topical calcipotriene-containing products, topical anthralin, topical steroids, topical immune modulators (Elidel, Protopic), and/or topical retinoids? ❑ **Yes** ❑ **No**

Select if the patient has had inadequate response or inability to tolerate the following:

❑ **Cimzia** (certolizumab) ❑ **Humira** (adalimumab) ❑ **Skyrizi** (risankizumab)

❑ **Stelara** (ustekinumab) ❑ **Tremfya** (guselkumab)

Is this request for continuation of therapy with the requested product? ❑ **Yes** ❑ **No**

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? ❑ **Yes** ❑ **No**

Polyarticular Juvenile Idiopathic Arthritis (PJIA):

For **Actemra SQ** (tocilizumab), **Orencia SQ** (abatacept), or **Xeljanz** (tofacitinib) requests:

Does the patient have moderate to severe PJIA? ❑ **Yes** ❑ **No**

Has the patient had inadequate response or inability to tolerate **Humira** (adalimumab)? ❑ **Yes** ❑ **No**

Is this request for continuation of therapy with the requested product? ❑ **Yes** ❑ **No**

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? ❑ **Yes** ❑ **No**

For **Enbrel** (etanercept) requests:

Does the patient have moderate to severe PJIA? ❑ **Yes** ❑ **No**

Select if the patient has had inadequate response or inability to tolerate the following:

❑ **Actemra** (tocilizumab) ❑ **Humira** (adalimumab)

❑ **Orencia SQ** (abatacept) ❑ **Xeljanz** tablets and oral solution (tofacitinib)

Is this request for continuation of therapy with the requested product? ❑ **Yes** ❑ **No**

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? ❑ **Yes** ❑ **No**

For **Humira** (adalimumab) requests**:**

Does the patient have moderate to severe PJIA? ❑ **Yes** ❑ **No**

Has the patient had inadequate response or inability to tolerate one of the following disease-modifying anti-rheumatic drugs (DMARDs): Methotrexate, hydroxychloroquine, leflunomide, azathioprine, sulfasalazine? ❑ **Yes** ❑ **No**

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? ❑ **Yes** ❑ **No**

Psoriatic Arthritis:

For **Cimzia** (certolizumab), **Humira** (adalimumab), **Otezla** (apremilast), **Simponi** (golimumab), **Stelara** (ustekinumab) or **Tremfya** (guselkumab) requests:

Does the patient have moderate to severe psoriatic arthritis? ❑ **Yes** ❑ **No**

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? ❑ **Yes** ❑ **No**

For **Cosentyx** (secukinumab) or **Enbrel** (etanercept) requests:

Does the patient have moderate to severe psoriatic arthritis? ❑ **Yes** ❑ **No**

Select if the patient has had inadequate response or inability to tolerate the following:

❑ **Cimzia** (certolizumab) ❑ **Humira** (adalimumab) ❑ **Orencia SQ** (abatacept) ❑ **Simponi** (golimumab)

❑ **Stelara** (ustekinumab) ❑ **Taltz** (ixekizumab) ❑ **Tremfya** (guselkumab)

❑ **Xeljanz/Xeljanz XR** tablets/extended-release tablets (tofacitinib)

Is this request for continuation of therapy with the requested product? ❑ **Yes** ❑ **No**

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? ❑ **Yes** ❑ **No**

For **Orencia SQ** (abatacept), **Taltz** (ixekizumab), or **Xeljanz/Xeljanz XR** tablets/extended-release tablets (tofacitinib) requests:

Does the patient have moderate to severe psoriatic arthritis? ❑ **Yes** ❑ **No**

Select if the patient has had inadequate response or inability to tolerate the following:

❑ **Cimzia** (certolizumab) ❑ **Humira** (adalimumab) ❑ **Simponi** (golimumab)

❑ **Stelara** (ustekinumab) ❑ **Tremfya** (guselkumab)

Is this request for continuation of therapy with the requested product? ❑ **Yes** ❑ **No**

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? ❑ **Yes** ❑ **No**

Recurrent Pericarditis:

For **Arcalyst** (rilonacept) requests:

Is Arcalyst being used for the treatment of recurrent pericarditis and reduction in risk of recurrence? ❑ **Yes** ❑ **No**

Was Arcalyst prescribed by or in consultation with a cardiologist? ❑ **Yes** ❑ **No**

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? ❑ **Yes** ❑ **No**

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Rheumatoid Arthritis:

For **Actemra SQ** (tocilizumab) or **Orencia SQ** (abatacept) requests:

Does the patient have moderate to severe rheumatoid arthritis? ❑ **Yes** ❑ **No**

Select if the patient has had inadequate response or inability to tolerate the following:

❑ **Cimzia** (certolizumab) ❑ **Humira** (adalimumab) ❑ **Rinvoq** (upadacitinib)

❑ **Simponi** (golimumab) ❑ **Xeljanz/Xeljanz XR** (tofacitinib)

Is this request for continuation of therapy with the requested product? ❑ **Yes** ❑ **No**

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? ❑ **Yes** ❑ **No**

For **Cimzia** (certolizumab), **Humira** (adalimumab), **Rinvoq** (upadacitinib), **Simponi** (golimumab), or **Xeljanz/Xeljanz XR** (tofacitinib) requests:

Does the patient have moderate to severe rheumatoid arthritis? ❑ **Yes** ❑ **No**

Has the patient had inadequate response or inability to tolerate one of the following disease-modifying anti-rheumatic drugs (DMARDs): Methotrexate, hydroxychloroquine, leflunomide, azathioprine, sulfasalazine? ❑ **Yes** ❑ **No**

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? ❑ **Yes** ❑ **No**

For **Enbrel** (etanercept), **Kevzara** (sarilumab), **Kineret** (anakinra), or **Olumiant** (baricitinib) requests:

Does the patient have moderate to severe rheumatoid arthritis? ❑ **Yes** ❑ **No**

Select if the patient has had inadequate response or inability to tolerate the following:

❑ **Actemra SQ** (tocilizumab) ❑ **Cimzia** (certolizumab) ❑ **Humira** (adalimumab) ❑ **Orencia SQ** (abatacept)

❑ **Rinvoq** (upadacitinib) ❑ **Simponi** (golimumab) ❑ **Xeljanz/Xeljanz XR** (tofacitinib)

Is this request for continuation of therapy with the requested product? ❑ **Yes** ❑ **No**

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? ❑ **Yes** ❑ **No**

Systemic Juvenile Idiopathic Arthritis (SJIA):

For **Actemra SQ** (tocilizumab) requests:

Does the patient have active systemic juvenile idiopathic arthritis (SJIA)? ❑ **Yes** ❑ **No**

Select if the patient has had inadequate response or inability to tolerate one of the following:

❑ DMARDs (e.g. leflunomide, methotrexate)

❑ Non-steroidal anti-inflammatory drug (NSAID) (e.g., ibuprofen)

❑ Systemic glucocorticoid (e.g., prednisone)

Systemic sclerosis-associated interstitial lung disease (SSc-ILD):

For **Actemra SQ** (tocilizumab) requests:

Was the diagnosis of SSc-ILD confirmed by a High Resolution CT scan or biopsy? ❑ **Yes** ❑ **No**

Select if the patient has had inadequate response or inability to tolerate the following:

❑ Azathioprine

❑ Cyclophosphamide

❑ Mycophenolate

Was Actemra prescribed by or in consultation with a pulmonologist? ❑ **Yes** ❑ **No**

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? ❑ **Yes** ❑ **No**

Ulcer of the mouth associated with Behcet's syndrome:

For **Otezla** (apremilast) requests:

Has the patient had inadequate response or inability to tolerate systemic corticosteroids, topical corticosteroids, or topical sucralfate? ❑ **Yes** ❑ **No**

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? ❑ **Yes** ❑ **No**

Immune Modulating Therapy Prior Authorization Request Form (Page 6 of 6)

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Ulcerative Colitis:

For **Humira** (adalimumab), **Simponi** (golimumab) or **Stelara** (ustekinumab) requests:

Does the patient have moderate to severe ulcerative colitis? ❑ **Yes** ❑ **No**

Has the patient had inadequate response or inability to tolerate one of the following medications: Corticosteroids, azathioprine, and/or 6-mercaptopurine? ❑ **Yes** ❑ **No**

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? ❑ **Yes** ❑ **No**

For **Xeljanz/Xeljanz XR** tablets/extended-release tablets (tofacitinib) requests:

Does the patient have moderate to severe ulcerative colitis? ❑ **Yes** ❑ **No**

Has the patient had inadequate response or inability to tolerate one of the following medications: Corticosteroids, azathioprine, 6-mercaptopurine? ❑ **Yes** ❑ **No**

Select if the patient has inadequate response or inability to tolerate the following:

❑ **Humira** (adalimumab) ❑ **Simponi** (golimumab) ❑ **Stelara** (ustekinumab)

Is this request for continuation of therapy with the requested product? ❑ **Yes** ❑ **No**

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? ❑ **Yes** ❑ **No**

Uveitis:

For **Humira** (adalimumab) requests**:**

Does the patient have non-infectious intermediate, posterior, or panuveitis? ❑ **Yes** ❑ **No**

Has the patient had inadequate response or inability to tolerate ophthalmic and oral corticosteroids? ❑ **Yes** ❑ **No**

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? ❑ **Yes** ❑ **No**

Reauthorization:

If this is a reauthorization request, answer the following:

Is there documentation of positive clinical response to therapy? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.