Alabama Medicaid Pharmacy
DMARD/Biological Injectables Prior Authorization Request Form

FAX: (800) 748-0116
Phone: (800) 748-0130

Fax or Mail to
Kepro

P.O. Box 3210
Auburn, AL 36831-3210

PATIENT INFORMATION

Patient name _____ Patient Medicaid # _____

Patient DOB _____ Patient phone # with area code _____

PRESCRIBER INFORMATION

Prescriber name _____ NPI # _____ License # _____

Phone # with area code _____ Fax # with area code _____

Address (Optional) _____

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I will be supervising the patient's treatment. Supporting documentation is available in the patient record.

_____
Prescriber Signature Date

CLINICAL INFORMATION

Drug Requested: ❒ Actemra ❒ Adbry ❒ Arava ❒ Avsola ❒ Cibinqo ❒ Cimzia ❒ Cinqair ❒ Cosentyx ❒ Dupixent ❒ Enbrel ❒ Entyvio ❒ Fasenra ❒ Humira ❒ Ilumya ❒ Inflectra ❒ Kevzara ❒ Kineret ❒ Lupkynis ❒ Myalept ❒ Nucala ❒ Olumiant ❒ Orencia ❒ Otezla ❒ Remicade ❒ Renflexis ❒ Rinvoq ❒ Siliq ❒ Simponi ❒ Skyrizi ❒ Stelara ❒ Taltz ❒ Tremfya ❒ Xeljanz

Pharmacy Claim Request:

NDC/J Code _____ Strength _____ Qty. _____ Days' Supply _____

Current weight: _____ ICD-10 Code _____ Number of Refills _____

Physician Administered/Medical Claim Request:

J Code _____ Strength _____ J Code Units _____ Days' Supply _____

Current weight: _____ ICD-10 Code _____

Please check the appropriate diagnosis below and answer diagnosis specific questions:

❒ **Ankylosing Spondylitis (AS) or Non-Radiographic Axial Spondyloarthritis (NRAS)**
- Is therapy approved by a board certified rheumatologist? ❒ Yes ❒ No
- Has the patient failed a 3 month treatment trial with at least 2 NSAIDs? If yes, attach documentation. ❒ Yes ❒ No
- For symptomatic peripheral arthritis, has the patient failed a 30-day treatment trial with at least one nonbiologic DMARD? If yes, attach documentation. ❒ Yes ❒ No

❒ **Atopic Dermatitis**
- Is therapy approved by a board-certified dermatologist? ❒ Yes ❒ No
- Has the patient failed a 6-month treatment trial with at least one topical prescription treatment within the past 12 months? Include past therapies _____ ❒ Yes ❒ No

❒ **Chronic Rhinosusitis with Nasal Polyps (CRSwNP)**
- Does the patient have a diagnosis of CRSwNP despite prior sino-nasal surgery or treatment with, or who are ineligible to receive or were intolerant to, systemic corticosteroids in the past 2 years? ❒ Yes ❒ No
- Is the patient currently taking an intranasal corticosteroid? ❒ Yes ❒ No

❒ **Crohn's Disease (CD) or Ulcerative Colitis (UC)**
- Is therapy approved by a board certified gastroenterologist? ❒ Yes ❒ No
- Has the patient failed a 30-day treatment trial with at least one or more conventional therapies? If yes, attach documentation. ❒ Yes ❒ No
- For Entyvio or Stelara, has the patient failed a 30-day treatment trial with at least one of the following: a tumor necrosis factor blocker, immunomodulator, or corticosteroid? If yes, attach documentation. ❒ Yes ❒ No

❒ **Cryopyrin-Associated Periodic Syndrome**
- Is there a diagnosis of cryopyrin-associated periodic syndrome/neonatal-onset multisystem inflammatory disease? ❒ Yes ❒ No

❒ **Cytokine Release Syndrome**
- Is there a diagnosis of chimeric antigen receptor (CAR) T cell-induced severe or life threatening cytokine release syndrome? ❒ Yes ❒ No

❒ **Deficiency of Interleukin-1 Receptor Antagonist**
- Does the patient have a diagnosis of Deficiency of Interleukin-1 Receptor Antagonist? ❒ Yes ❒ No

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❒ **Enthesitis-Related Arthritis**
- Does the patient have a diagnosis of Enthesitis-Related Arthritis? ❒ Yes ❒ No

❒ **Eosinophilic Esophagitis**
- Does the patient have a diagnosis of Eosinophilic Esophagitis? ❒ Yes ❒ No

❒ **Eosinophilic/Corticosteroid-Dependent Asthma**
- Is therapy approved by a board-certified pulmonologist or allergist? ❒ Yes ❒ No
- Has the patient had a positive blood or sputum test for asthma with an eosinophilic phenotype? If yes, indicate blood eosinophil count or sputum eosinophil count_____ ❒ Yes ❒ No
- Does the patient have oral corticosteroid dependent asthma? ❒ Yes ❒ No
- Is the patient symptomatic despite receiving a combination of either inhaled corticosteroid and a leukotriene inhibitor or an inhaled corticosteroid and long acting beta agonist, or has the patient required 3 or more bursts of oral steroids within the past 12 months? Include past therapies_____ ❒ Yes ❒ No

❒ **Eosinophilic Granulomatosis with Polyangiitis**
- Is there a diagnosis of eosinophilic granulomatosis with polyangiitis? ❒ Yes ❒ No

❒ **Generalized Lipodystrophy**
- Is the request for treatment of complications of lipodystrophy, liver disease, HIV-related lipodystrophy, or general obesity not associated with generalized lipodystrophy? ❒ Yes ❒ No
- Is therapy being used as an adjunct to dietary restrictions? ❒ Yes ❒ No

❒ **Graft vs. Host Disease Prophylaxis**
- Is there a diagnosis of acute graft versus host disease prophylaxis? ❒ Yes ❒ No
- Is the requested drug being used in combination with a calcineurin inhibitor and methotrexate? ❒ Yes ❒ No

❒ **Giant Cell Arteritis**
- Is there a diagnosis of giant cell arteritis? ❒ Yes ❒ No
- Is the patient currently on a glucocorticoid regimen, recently discontinued glucocorticoids, or is there a contraindication to glucocorticoid use? Indicate past/current therapies _____ ❒ Yes ❒ No

❒ **Hidradenitis Suppurativa**
- Is therapy approved by a board certified dermatologist? ❒ Yes ❒ No
- Has the patient failed a treatment trial with at least one systemic antibiotic in the past 12 months? ❒ Yes ❒ No

❒ **Juvenile Idiopathic Arthritis (JIA)**
- Is therapy approved by a board certified rheumatologist? ❒ Yes ❒ No
- Has the patient failed a 30-day treatment trial with at least one nonbiologic DMARD? If yes, attach documentation. ❒ Yes ❒ No

❒ **Lupus Nephritis**
- Does the patient have a diagnosis of active Lupus Nephritis? ❒ Yes ❒ No
- Does the patient have background immunosuppressive therapy regimen containing mycophenolate mofetil and corticosteroids? ❒ Yes ❒ No
- Does the patient have an established baseline estimated glomerular filtration rate (eGFR) >45 mL/min/1.73 m2 and blood pressure ≤165/105? ❒ Yes ❒ No

❒ **Oral Ulcers Associated with Behçet's Disease**
- Does the patient have a diagnosis of Oral Ulcers associated with Behçet's Disease? ❒ Yes ❒ No
- Has the patient had an inadequate response, adverse reaction, or contraindication to topical corticosteroids? ❒ Yes ❒ No

❒ **Plaque Psoriasis (PP)**
- Is therapy approved by a board certified dermatologist? ❒ Yes ❒ No
- Has the patient failed a 6 month treatment trial with at least 1 topical treatment (generic, OTC, or brand) within the past year? If yes, attach documentation. ❒ Yes ❒ No
- Has the patient had an inadequate response to phototherapy, systemic retinoids, methotrexate, or cyclosporin? ❒ Yes ❒ No

❒ **Psoriatic Arthritis (PA)**
- Is therapy approved by a board certified rheumatologist or dermatologist? ❒ Yes ❒ No
- Has the patient failed a 30-day treatment trial with at least one nonbiologic DMARD? If yes, attach documentation. ❒ Yes ❒ No

❒ **Rheumatoid Arthritis (RA)**
- Is therapy approved by a board certified rheumatologist? ❒ Yes ❒ No
- Has the patient failed a 30-day treatment trial with at least one nonbiologic DMARD? If yes, attach documentation. ❒ Yes ❒ No
- For newly diagnosed moderate to severe RA (<6 months), does the patient have high disease activity with features of a poor prognosis for < 3 months **or** high disease activity for 3-6 months (without prognostic features) and therapy is being initiated with methotrexate and a biological injectable? If yes, indicate specific markers, values and features._____ ❒ Yes ❒ No
- For Actemra, does the patient have moderate to severe RA with an inadequate response to one or more anti-TNFα therapies? ❒ Yes ❒ No

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❒ **Systemic Sclerosis-Associated Interstitial Lung Disease**

- Does the patient have a diagnosis of active Systemic Sclerosis-Associated Interstitial Lung Disease? ❒ Yes ❒ No

❒ **Uveitis**

- Is therapy approved by a board certified ophthalmologist? ❒ Yes ❒ No
- Has the patient failed a treatment trial with at least one topical glucocorticoid treatment within the past 12 months? ❒ Yes ❒ No

Medical Justification: _____

_____

_____

DISPENSING PHARMACY INFORMATION

May Be Completed by Pharmacy

Dispensing pharmacy_____NPI #_____NDC #_____

Phone # with area code_____Fax # with area code _____