

CYTOKINE AND CAM ANTAGONISTS

PRIOR AUTHORIZATION REQUEST

PRESCRIBER FAX FORM

ONLY the prescriber may complete and fax this form. This form is for prospective, concurrent, and retrospective reviews.

Incomplete forms will be returned for additional information. The following documentation is required for prior authorization consideration. For formulary information and to download additional forms, please visit https://www.bcbstx.com/provider/medicaid/rx_prior_auth.html

PATIENT AND INSURANCE INFORMATION

Today's Date: _____

| | | | |
|-----------------------|-------|-------------------|--------------------|
| Patient Name (First): | Last: | M: | DOB (mm/dd/yy): |
| Patient Address: | | City, State, Zip: | Patient Telephone: |
| BCBSTX ID Number: | | Group Number: | |

PRESCRIBER/CLINIC INFORMATION

| | | | |
|-------------------|------------------|-----------------|---------------|
| Prescriber Name: | Prescriber NPI#: | Specialty: | Contact Name: |
| Clinic Name: | | Clinic Address: | |
| City, State, Zip: | | Phone #: | Secure Fax #: |

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis- ICD code plus description: _____

Medication Requested: _____ Strength: _____

Dosing Schedule: _____ Quantity per Month: _____

1. Is the patient currently treated with the requested medication? Yes No
If yes, when was treatment with the requested medication started? _____

2. Has the patient had any of the following conditions in the last 730 days? (check all that apply) Yes No

| | |
|----------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|
| <input type="checkbox"/> Ankylosing spondylitis | <input type="checkbox"/> Crohn's disease |
| <input type="checkbox"/> Cryopyrin-associated periodic syndrome (CAPS) | <input type="checkbox"/> Familial cold auto-inflammatory syndrome (FCAS) |
| <input type="checkbox"/> Familial Mediterranean fever (FMF) | <input type="checkbox"/> Giant cell arteritis (GCA) |
| <input type="checkbox"/> Hidradenitis suppurativa (HS) | <input type="checkbox"/> Hyperimmunoglobulin D syndrome (HIDS) |
| <input type="checkbox"/> Mevalonate kinase deficiency (MKD) | <input type="checkbox"/> Moderate-to-severe plaque psoriasis |
| <input type="checkbox"/> Muckle-Wells syndrome (MWS) | <input type="checkbox"/> Polyarticular juvenile idiopathic arthritis (PJIA) |
| <input type="checkbox"/> Psoriatic arthritis (PA) | <input type="checkbox"/> Rheumatoid arthritis (RA) |
| <input type="checkbox"/> Systemic juvenile idiopathic arthritis (SJIA) | <input type="checkbox"/> Ulcerative colitis (UC) |
| <input type="checkbox"/> Tumor necrosis factor receptor-associated periodic syndrome (TRAPS) | <input type="checkbox"/> Uveitis (UV) |
| <input type="checkbox"/> Cytokine release syndrome (CRS) | <input type="checkbox"/> Non-radiographic axial spondyloarthritis |
| <input type="checkbox"/> Oral ulcers associated with Behcet's disease | <input type="checkbox"/> Other: _____ |

3. Does the patient have a history of a demyelinating disease (multiple sclerosis, optic neuritis, Guillain-Barre syndrome) in the last 365 days? Yes No

4. Does the patient have a history of heart failure in the last 365 days? Yes No

5. Does the patient have a history of hematologic abnormalities? Yes No
If yes, please provide date(s): _____

6. Does the patient have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days? Yes No

7. Has the patient tried a disease-modifying antirheumatic drug (DMARD)? Yes No
If no, does the patient have a contraindication to or is non-responsive to DMARD therapy? Yes No

8. Please list all reasons for selecting the requested **medication, strength, and quantity** over alternatives (e.g., contraindications, allergies, or history of adverse drug reactions to alternatives, lower dose has been tried). _____

9. Please list all other medications the patient is **currently taking** for treatment of this diagnosis. _____

10. Please list the medications the patient has **previously tried and failed** for treatment of this diagnosis (Please specify if brand name, generic, extended-release products, or OTC products):

| | | | |
|-------|----------------|-------|----------------|
| _____ | Date(s): _____ | _____ | Date(s): _____ |
| _____ | Date(s): _____ | _____ | Date(s): _____ |
| _____ | Date(s): _____ | _____ | Date(s): _____ |

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| | | | |
|-----------------------|-------|----|-------------------|
| Patient Name (First): | Last: | M: | DOB (mm/dd/yyyy): |
|-----------------------|-------|----|-------------------|

For Humira Requests:

11. Has the patient had a 30-day trial with conventional therapy in the last 90 days? Yes No

If yes, please document agent tried: _____

For Kevzara Requests:

12. Does the patient have a diagnosis of active hepatic disease or hepatic impairment in the last 365 days? Yes No

For Olumiant Requests:

13. Does the patient have a diagnosis that indicates increased risk of GI perforation, thrombosis, or malignancy in the last 180 days? Yes No

14. Does the patient have a diagnosis of severe renal (eGFR <60 mL/min/1.73m²) or severe hepatic impairment in the last 365 days? Yes No

For Otezla Requests:

15. Does the patient have a diagnosis of chronic kidney disease (stage 4 or 5) in the last 365 days? Yes No

For Rinvoq Requests:

16. Has the patient tried methotrexate? Yes No

If no, does the patient have an inadequate response or intolerance to methotrexate? Yes No

17. Does the patient have a diagnosis of severe hepatic impairment in the last 365 days? Yes No

For Siliq Requests:

18. Has the patient had a 30-day trial with conventional therapy for plaque psoriasis in the last 90 days? Yes No

If yes, please document agent tried: _____

19. Does the patient have a diagnosis of Crohn's disease in the last 365 days? Yes No

For Stelara Requests:

20. Has the patient had a 30-day trial for an immunomodulator, corticosteroid, or TNF blocker in the last 180 days? . Yes No

For Taltz Requests:

21. Does the patient have a diagnosis of Crohn's disease or ulcerative colitis in the last 365 days? Yes No

Prescriber or Authorized Signature: _____ **Date:** _____

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility Authorization does not guarantee payment.

Please fax or mail this form to:

Prime Therapeutics LLC, Clinical Review Department
2900 Ames Crossing Road
Eagan, Minnesota 55121

TOLL FREE

Fax: 877.243.6930 Phone: 855.457.0407

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