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/pharmacy/rx-prior-auth

Patient Name (First): Last: M. DOB (mmiddlyy):	PAT	IENT AND INSURANCE INFORI	MATION	, p			T	oday's	Date:	amasynx prisi addi	
BCBSTX ID Number: PRESCRIBERCLINIC INFORMATION Prescriber Name: Clinic Name: Clinic Address: Cliv, 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: For all requests: 1. Is the patient currently treated with the requested medication? If yes, when was treatment with the requested medication started? 2. Has the patient bad any of the following conditions in the last 730 days? (check all that apply) Ankiylosing spondylitis Ankiylosing spondylitis Crophri-associated periodic syndrome (CAPS) Familial cold auto-inflammatory syndrome (FCAS) Familial Mediterranean fever (FMF) Glant cell arteritis (GCA) Hyperimmunojodubin D syndrome (HIDS) Moute-Wells syndrome (MMS) Pseriatic arthritis (PA) Systemic juvenile idiopathic arthritis (SJIA) Pseriatic arthritis (PA) Systemic juvenile idiopathic arthritis (SJIA) Pseriatic arthritis (PA) Systemic plus of the capture of the second of the syndrome (TRAPS) Contact Name Capture of the second of the								M:	DOB (mm/c	ld/yy):	
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Atopic Dermatitis	2.		ollowing	conditions in the l	last 73	0 days?	•			Yes 🗌 No	
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Deficiency of interleukin-1 receptor antagonist (DIRA)		☐ Oral ulcers associated with E	Behcet's (disease			☐ Recurre	nt Peri	carditis (RF	P)	
Neuromyelitis optica spectrum disorder (NMOSD)		☐ Systemic sclerosis-associated interstitial lung disease			(SSc-I	′ =			sease		
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Please continue to the next page.	8.										
Patient Name (First): Last: M: DOB (mm/dd/yyyy):	Ple	ase continue to the next page.									
	Pati	ent Name (First):		Last:					M:	DOB (mm/dd/yyyy):	

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9.	Please list all reasons for selecting the requested agent, stre contraindications, allergies, history of adverse drug reactions dose over FDA max).								
10.	Please list all agents the patient has previously tried and failed for treatment of this diagnosis (Please specify if the								
	has tried brand-name products, generic products, or over-the tried).	-counter products. Please specify start and end dates of dru	ugs						
	Date(s):	Date(s):							
	Date(s):								
	Date(s):	Date(s):							
For	Humira Requests:								
	1. Has the patient had at least a 30-day trial with conventional therapy for Crohn's disease (for patients with a diagnosis of CD) or conventional therapy for ulcerative colitis (for patients with a diagnosis of UC) in the last 180 days?								
	If yes, please document agent tried:								
For	Amjevita Requests:								
	Has the patient had a 30-day trial with conventional therapy in	n the last 180 days?	□ No						
12.	If yes, please document agent tried:	•							
For	Kevzara Requests:								
	Does the patient have a diagnosis of active hepatic disease of	er bonatic impairment in the last 365 days?	□ No						
		i flepatic impairment in the last 505 days?							
	Olumiant Requests:	uk of Claramenation throughout as maliananas in							
14.	Does the patient have a diagnosis that indicates increased ris		□ NIa						
45	the last 180 days?		□ ио						
	Does the patient have a diagnosis of severe renal (eGFR <30 in the last 365 days?		□No						
	Orencia Requests:								
	Will the patient be taking the requested drug in combination v Otezla Requests:	vith a calcineurin inhibitor and methotrexate? ☐ Yes	☐ No						
17.	Does the patient have a diagnosis of chronic kidney disease	(stage 4 or 5) in the last 365 days? Yes	□No						
	Rinvoq Requests:	, , , , , , , , , , , , , , , , , , , ,	_						
	Has the patient tried a TNF-blocker in the last 90 days?	□Yes	□No						
		olerance to TNF-blockers? Yes							
19	Does the patient have a diagnosis of severe hepatic impairme								
20.	20. Has the patient had therapy with at least one systemic agent in the last 90 days?								
For	Siliq Requests:	norance to a systemic agent:							
	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:								
	Does the patient have a diagnosis of Crohn's disease in the last 365 days? ☐ Yes ☐ Yes Telara Requests:								
23.	Has the patient had a 30-day trial for an immunomodulator, c	orticosteroid, or TNF blocker in the last 180 days?. ☐ Yes	☐ No						
For	Taltz Requests:								
24.	Does the patient have a diagnosis of Crohn's disease or ulce	rative colitis in the last 365 days? Yes	☐ No						
	-	Date:							
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									
treat	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.									
	: Payment is subject to member eligibility Authorization does not guar								
	se fax or mail this form to:	CONFIDENTIALITY NOTICE: This communication is intende							
	e Therapeutics LLC, Clinical Review Department	the use of the individual entity to which it is addressed and may contain							
) Ames Crossing Road an, Minnesota 55121	information that is privileged or confidential. If the reader of the message is not the intended recipient, you are hereby notified							
_ay	,	dissemination, distribution or copying of this communication is							
TO	I EBEE	prohibited. If you have received this communication in error, p							
	LL FREE	notify the sender immediately by telephone at 866.202.3474 a	and return						
Fax	: 877.243.6930 Phone: 855.457.0407	the original message to Prime Therapeutics via U.S. Mail. The for your cooperation.	ank you						

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