

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 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:
For all requests:	
1. Is the patient currently treated with the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when was treatment with the requested agent started? _____	
2. Has the patient had any of the following conditions in the last 730 days? (check all that apply) <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Alopecia areata <input type="checkbox"/> Atopic Dermatitis <input type="checkbox"/> Cryopyrin-associated periodic syndrome (CAPS) <input type="checkbox"/> Familial Mediterranean fever (FMF) <input type="checkbox"/> Hidradenitis suppurativa (HS) <input type="checkbox"/> Mevalonate kinase deficiency (MKD) <input type="checkbox"/> Muckle-Wells syndrome (MWS) <input type="checkbox"/> Psoriatic arthritis (PA) <input type="checkbox"/> Systemic juvenile idiopathic arthritis (SJIA) <input type="checkbox"/> Tumor necrosis factor receptor-associated periodic syndrome (TRAPS) <input type="checkbox"/> Cytokine release syndrome (CRS) <input type="checkbox"/> Oral ulcers associated with Behcet's disease <input type="checkbox"/> Systemic sclerosis-associated interstitial lung disease (SSc-ILD) <input type="checkbox"/> Deficiency of interleukin-1 receptor antagonist (DIRA) <input type="checkbox"/> Neuromyelitis optica spectrum disorder (NMOSD) <input type="checkbox"/> Prophylaxis of acute graft versus host disease (aGVHD) <input type="checkbox"/> Active tuberculosis (TB)	<input type="checkbox"/> Ankylosing spondylitis <input type="checkbox"/> Crohn's disease <input type="checkbox"/> Familial cold auto-inflammatory syndrome (FCAS) <input type="checkbox"/> Giant cell arteritis (GCA) <input type="checkbox"/> Hyperimmunoglobulin D syndrome (HIDS) <input type="checkbox"/> Active plaque psoriasis <input type="checkbox"/> Polyarticular juvenile idiopathic arthritis (PJIA) <input type="checkbox"/> Rheumatoid arthritis (RA) <input type="checkbox"/> Ulcerative colitis (UC) <input type="checkbox"/> Uveitis (UV) <input type="checkbox"/> Non-radiographic axial spondyloarthritis <input type="checkbox"/> Recurrent Pericarditis (RP) <input type="checkbox"/> Active Still's disease <input type="checkbox"/> Enthesitis-related arthritis <input type="checkbox"/> Active plaque psoriasis (PS) <input type="checkbox"/> Generalized pustular psoriasis (GPP) <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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Does the patient have a history of heart failure in the last 365 days? <input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Does the patient have a history of hematologic abnormalities? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Has the patient tried a disease-modifying antirheumatic drug (DMARD)? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, does the patient have a contraindication to or is non-responsive to a DMARD? <input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Please list all other medications the patient will take in combination with the requested medication for the treatment of this diagnosis. _____ _____ _____	

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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9. Please list all reasons for selecting the requested **agent, strength, dosing schedule, and quantity over alternatives** (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting 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 patient has tried brand-name products, generic products, or over-the-counter products. Please specify start and end dates of drugs tried).

_____	Date(s): _____	_____	Date(s): _____
_____	Date(s): _____	_____	Date(s): _____
_____	Date(s): _____	_____	Date(s): _____

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 Amjevita Requests:
 12. Has the patient had a 30-day trial with conventional therapy in the last 180 days? Yes No
If yes, please document agent tried: _____

For Bimzelx Requests:
 13. Does the client have a diagnosis of cirrhosis in the last 365 days? Yes No
 14. Does the client have a diagnosis of suicidal ideation in the last 365 days? Yes No

For Omvoh Requests:
 15. Does the client have a diagnosis of cirrhosis in the last 365 days? Yes No

For Kevzara Requests:
 16. Does the patient have a diagnosis of active hepatic disease or hepatic impairment in the last 365 days? Yes No

For Olumiant Requests:
 17. Does the patient have a diagnosis that indicates increased risk of GI perforation, thrombosis, or malignancy in the last 180 days? Yes No
 18. Does the patient have a diagnosis of severe renal (eGFR <30 mL/min/1.73m²) or severe hepatic impairment in the last 365 days? Yes No

For Orencia Requests:
 19. Will the patient be taking the requested drug in combination with a calcineurin inhibitor and methotrexate? Yes No

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

For Rinvoq Requests:
 21. Has the patient tried a TNF-blocker in the last 90 days? Yes No
If no, has the patient had an inadequate response or intolerance to TNF-blockers? Yes No
 22. Does the patient have a diagnosis of severe hepatic impairment in the last 365 days? Yes No
 23. Has the patient had therapy with at least one systemic agent in the last 90 days? Yes No
If no, has the patient had an inadequate response or intolerance to a systemic agent? Yes No

For Siliq Requests:
 24. 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: _____

For Spevigo Requests:
 25. Does the patient have a diagnosis of Crohn's disease in the last 365 days? Yes No
 26. Is this a renewal request, or has the client had initial treatment with intravenous Spevigo? Yes No

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

For Tyenne Requests:
 28. Is this a refill request, or has the client had initial treatment with intravenous tocilizumab? Yes No

For Taltz Requests:
 29. Does the patient have a diagnosis of Crohn's disease or ulcerative colitis in the last 365 days? Yes No

For Xeljanz Requests:
 30. Is this a refill request? 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 Suite 200
 Eagan, Minnesota 55121

TOLL FREE
Fax: 877.243.6930 Phone: 855.457.0407

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