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 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
   - ☐ Alopecia areata
   - ☐ Atopic Dermatitis
   - ☐ Cryopyrin-associated periodic syndrome (CAPS)
   - ☐ Familial Mediterranean fever (FMF)
   - ☐ Hidradenitis suppurativa (HS)
   - ☐ Mevalonate kinase deficiency (MKD)
   - ☐ Muckle-Wells syndrome (MWS)
   - ☐ Psoriatic arthritis (PA)
   - ☐ Systemic juvenile idiopathic arthritis (SJIA)
   - ☐ Tumor necrosis factor receptor-associated periodic syndrome (TRAPS)
   - ☐ Cytokine release syndrome (CRS)
   - ☐ Oral ulcers associated with Behcet's disease
   - ☐ Systemic sclerosis-associated interstitial lung disease (SSc-ILD)
   - ☐ Deficiency of interleukin-1 receptor antagonist (DIRA)
   - ☐ Neuromyelitis optica spectrum disorder (NMOSD)
   - ☐ Prophylaxis of acute graft versus host disease (aGVHD)
   - ☐ Ankylosing spondylitis
   - ☐ Crohn's disease
   - ☐ Familial cold auto-inflammatory syndrome (FCAS)
   - ☐ Giant cell arteritis (GCA)
   - ☐ Hyperimmunoglobulin D syndrome (HIDS)
   - ☐ Active plaque psoriasis
   - ☐ Polyarticular juvenile idiopathic arthritis (PJIA)
   - ☐ Rheumatoid arthritis (RA)
   - ☐ Ulcerative colitis (UC)
   - ☐ Uveitis (UV)
   - ☐ Non-radiographic axial spondyloarthritis
   - ☐ Recurrent Pericarditis (RP)
   - ☐ Active Still's disease
   - ☐ Enthesitis-related arthritis
   - ☐ Active plaque psoriasis (PS)
   - ☐ 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 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):

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 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? ☐ 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 Kevzara Requests:

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

For Olumiant Requests:

14. Does the patient have a diagnosis that indicates increased risk of GI perforation, thrombosis, or malignancy in the last 180 days? ☐ Yes ☐ No
15. Does the patient have a diagnosis of severe renal (eGFR <30 mL/min/1.73m^2) or severe hepatic impairment in the last 365 days? ☐ Yes ☐ No

For Orencia Requests:

16. Will the patient be taking the requested drug in combination with a calcineurin inhibitor and methotrexate? ☐ Yes ☐ No

For Otezla Requests:

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

For Rinvoq Requests:

18. 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
19. Does the patient have a diagnosis of severe hepatic impairment in the last 365 days? ☐ Yes ☐ No
20. 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:

21. 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: _____
22. Does the patient have a diagnosis of Crohn's disease in the last 365 days? ☐ Yes ☐ No

For Stelara Requests:

23. 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:

24. 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:
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TOLL FREE

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