Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Cytokine and CAM Antagonists

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Patient Name:	Prescriber Name:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Patient Primary Phone:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	
HPP's maximum approval time is 12 months but may be less depending on the drug.		

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is this a request for renewal of therapy with the requested drug (i.e., The requested drug has been previously approved on prior authorization)?

☐ Yes ☐ No

Q2. Is the requested drug prescribed for the treatment of a diagnosis that is indicated in the United States Food and Drug Administration (FDA)-approved package labeling or a medically accepted indication?

☐ Yes ☐ No

Q3. Is the patient age-appropriate according to the Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia or peer-reviewed medical literature?

☐ Yes ☐ No

Q4. Is the requested drug prescribed by or in consultation with an appropriate specialist (e.g., gastroenterologist, dermatologist, rheumatologist, ophthalmologist, immunologist, genetic specialist, pulmonologist, oncologist, etc.)?

☐ Yes ☐ No

Q5. If currently using a different Cytokine and CAM Antagonist, will discontinue the use of that Cytokine and CAM Antagonist prior to starting the requested medication or requires the use of 2 Cytokine antagonists according to peer-reviewed medical literature, or has 2 or more diseases for which a single agent is not sufficient?

☐ Yes ☐ No

Q6. Does the patient have any contraindications to the requested drug?

☐ Yes ☐ No

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Q7. Is the prescribed dose and duration of therapy consistent with the Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia or peer-reviewed medical literature?

☐ Yes ☐ No

Q8. Is the requested drug associated with an increased risk of infection according to the Food and Drug Administration (FDA)-approved package labeling?

☐ Yes ☐ No

Q9. Has the patient been evaluated for active or latent tuberculosis infection documented by results of a tuberculin skin test (purified protein derivative [PPD]) or blood test (interferon-gamma release assay)?

☐ Yes ☐ No

Q10. Has the patient been evaluated for Hepatitis B infection documented by results of anti-HBs, HBsAg, and anti-HBc?

☐ Yes ☐ No

Q11. Is the requested drug associated with behavioral and/or mood changes as stated in the Food and Drug Administration (FDA)-approved package labeling (e.g., Otezla, Siliq)?

☐ Yes ☐ No

Q12. Has the patient been evaluated for a history of prior suicide attempt, bipolar disorder or major depressive disorder?

☐ Yes ☐ No

Q13. Does the patient have a diagnosis of moderate-to-severe Crohn's disease?

☐ Yes ☐ No

Q14. Has the patient failed to achieve remission with or has a contraindication or intolerance to an induction course of corticosteroids?

☐ Yes ☐ No

Q15. Has the patient failed to maintain remission with a conventional immunomodulator in accordance with current consensus guidelines OR does the patient have a contraindication or intolerance to conventional immunomodulators in accordance with current consensus guidelines?

☐ Yes ☐ No

Q16. Does the patient have a diagnosis of Crohn's disease that is associated with one or more high-risk or poor prognostic features?

☐ Yes ☐ No

Q17. Has the patient achieved remission with the requested drug?

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☐ Yes ☐ No

Q18. Will the requested drug be used as maintenance therapy to maintain remission?

☐ Yes ☐ No

Q19. Does the patient have a diagnosis of ulcerative colitis (UC)?

☐ Yes ☐ No

Q20. Does the patient have mild ulcerative colitis associated with multiple poor prognostic factors?

☐ Yes ☐ No

Q21. Is the ulcerative colitis moderate-to-severe?

☐ Yes ☐ No

Q22. Has the patient failed to achieve remission with or has a contraindication or intolerance to an induction course of corticosteroids?

☐ Yes ☐ No

Q23. Has the patient failed to maintain remission with a conventional immunomodulator in accordance with current consensus guidelines OR does the patient have a contraindication or intolerance to conventional immunomodulators in accordance with current consensus guidelines?

☐ Yes ☐ No

Q24. Has the patient achieved remission with the requested drug?

☐ Yes ☐ No

Q25. Will the requested drug be used as maintenance therapy to maintain remission?

☐ Yes ☐ No

Q26. Does the patient have a diagnosis of moderately-to-severely active rheumatoid arthritis?

☐ Yes ☐ No

Q27. Does the patient have a history of therapeutic failure of a 3-month trial of a conventional non-biologic disease-modifying antirheumatic drug (DMARD) in accordance with current consensus guidelines?

☐ Yes ☐ No

Q28. Does the patient have a contraindication or intolerance to conventional non-biologic disease-modifying antirheumatic drugs (DMARDs)?

☐ Yes ☐ No

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Patient Name:	Prescriber Name:

Q29. Does the patient have a diagnosis of juvenile idiopathic arthritis (JIA)?

☐ Yes ☐ No

Q30. Does the patient have a history of therapeutic failure, contraindication or intolerance to a 3-month trial of a conventional non-biologic disease-modifying antirheumatic drug (DMARD)?

☐ Yes ☐ No

Q31. Does the patient have systemic juvenile idiopathic arthritis (JIA) with active systemic features?

☐ Yes ☐ No

Q32. Does the patient have a diagnosis of juvenile idiopathic arthritis (JIA) with involvement of high-risk joints, high disease activity, or at high risk of disabling joint damage?

☐ Yes ☐ No

Q33. Does the patient have active sacroilitis and/or enthesitis?

☐ Yes ☐ No

Q34. Does the patient have a history of therapeutic failure of a two-week trial of an oral non-steroidal anti-inflammatory drug (NSAID)?

☐ Yes ☐ No

Q35. Does the patient have a contraindication or intolerance to oral nonsteroidal anti-inflammatory drugs (NSAIDs)?

☐ Yes ☐ No

Q36. Does the patient have a diagnosis of ankylosing spondylitis or other axial spondyloarthritis?

☐ Yes ☐ No

Q37. Does the patient have a history of therapeutic failure of a 2-week trial of continuous treatment with two different oral nonsteroidal anti-inflammatory drugs [NSAIDs] (i.e., an oral NSAID taken daily for two weeks and a different oral NSAID taken daily for 2 weeks)?

☐ Yes ☐ No

Q38. Does the patient have a contraindication or intolerance to oral nonsteroidal anti-inflammatory drugs (NSAIDs)?

☐ Yes ☐ No

Q39. Does the patient have a diagnosis of active psoriatic arthritis?

☐ Yes ☐ No

Q40. Does the patient have axial disease, dactylitis, and/or enthesitis?

☐ Yes ☐ No

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Patient Name:	Prescriber Name:

Q41. Does the patient have one of the following?

☐ Yes ☐ No

Q42. Does the patient have history of therapeutic failure of an eight-week trial of a conventional non-biologic disease-modifying anti-inflammatory drug (DMARD), or a contraindication or intolerance to conventional non-biologic DMARDs?

☐ Yes ☐ No

Q43. Does the patient have severe disease as determined by the prescriber?

☐ Yes ☐ No

Q44. Does the patient have concomitant moderate-to-severe nail disease?

☐ Yes ☐ No

Q45. Does the patient have concomitant active inflammatory bowel disease?

☐ Yes ☐ No

Q46. Does the patient have chronic psoriasis?

☐ Yes ☐ No

Q47. Does the patient have psoriasis associated with at least one of the following: A) A body surface area (BSA) of 3 percent or more that is affected, B) A BSA of less than 3 percent that is affected with involvement of critical areas, C) Significant disability or impairment of physical, mental, or psychosocial functioning?

☐ Yes ☐ No

Q48. Does the patient have moderate to severe nail disease?

☐ Yes ☐ No

Q49. Does the patient have history of therapeutic failure of a 4-week trial of topical corticosteroids or an 8-week trial of other topical pharmacologic therapy?

☐ Yes ☐ No

Q50. Does the patient have a contraindication or intolerance to topical corticosteroids and other topical pharmacologic therapy?

☐ Yes ☐ No

Q51. Does the patient have a history of therapeutic failure of or a contraindication or an intolerance to at least one of the following: a 3 month trial of conventional systemic therapy OR phototherapy?

☐ Yes ☐ No

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Q52. Does the patient have a diagnosis of moderate-to-severe hidradenitis suppurativa?

☐ Yes ☐ No

Q53. For Hurley Stage II disease does the patient have a history of therapeutic failure, contraindication or intolerance to both of the following: A) A three-month trial of topical clindamycin, OR B) An adequate trial of systemic antibiotics?

☐ Yes ☐ No

Q54. For Hurley stage III disease does the patient have one of the following: A) History of therapeutic failure of or contraindication or intolerance to an adequate trial of systemic antibiotic, OR B) Is a candidate for or has a history of surgical intervention for HS?

☐ Yes ☐ No

Q55. Does the patient have a diagnosis of non-infectious uveitis?

☐ Yes ☐ No

Q56. Is the diagnosis of uveitis associated with juvenile idiopathic arthritis (JIA) or Behcet's syndrome?

☐ Yes ☐ No

Q57. Does the patient have a history of therapeutic failure, contraindication or intolerance to one of the following: A) A systemic, topical, intraocular or periocular corticosteroid or B) A conventional systemic immunosuppressive?

☐ Yes ☐ No

Q58. Does the patient have corticosteroid-dependent uveitis?

☐ Yes ☐ No

Q59. Will the requested drug be used with the intent of discontinuing or decreasing the dose of the systemic corticosteroid?

☐ Yes ☐ No

Q60. Does the patient have a diagnosis of giant cell arteritis?

☐ Yes ☐ No

Q61. Does the patient have history of therapeutic failure, contraindication or intolerance to systemic glucocorticoids?

☐ Yes ☐ No

Q62. Is the patient at high-risk for glucocorticoid-related complications?

☐ Yes ☐ No

Q63. Does the patient have glucocorticoid-dependent disease?

☐ Yes ☐ No

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Q64. Will the requested drug be used with the intent of discontinuing or decreasing the dose of the systemic glucocorticoid?

☐ Yes ☐ No

Q65. Does the patient have a diagnosis of familial Mediterranean fever?

☐ Yes ☐ No

Q66. Does the patient have a history of therapeutic failure of at least a three-month trial with colchicine at maximally tolerated doses or a contraindication or intolerance to colchicine?

☐ Yes ☐ No

Q67. Does the patient have a diagnosis of Behcet's syndrome?

☐ Yes ☐ No

Q68. Has the diagnosis of Behcet's syndrome been confirmed by current consensus guidelines?

☐ Yes ☐ No

Q69. Does the patient have recurrent ulcers associated with Behcet's syndrome?

☐ Yes ☐ No

Q70. Does the patient have a history of therapeutic failure with, contraindication or intolerance to a topical corticosteroid (e.g., triamcinolone dental paste)?

☐ Yes ☐ No

Q71. Does the patient have a history of one of the following: A) Therapeutic failure of an adequate trial of colchicine at maximally tolerated doses or B) A contraindication or intolerance to colchicine?

☐ Yes ☐ No

Q72. Does the patient have a diagnosis of adult-onset Still's disease?

☐ Yes ☐ No

Q73. Does the patient have predominantly systemic disease?

☐ Yes ☐ No

Q74. Does the patient have a history of therapeutic failure, contraindication or intolerance to systemic glucocorticoids?

☐ Yes ☐ No

Q75. Does the patient have alopecia areata?

☐ Yes ☐ No

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Q76. Does the patient have alopecia associated with at least one of the following: A) Alopecia universalis, B) Alopecia totalis, C) Greater than 50% scalp involvement, D) Significant disability or impairment of physical, mental, or psychosocial functioning?

☐ Yes ☐ No

Q77. Does the patient have a current episode of alopecia areata of greater than 6 months duration?

☐ Yes ☐ No

Q78. For an oral Janus Kinase (JAK) inhibitor, one of the following: A) History of therapeutic failure of at least one tumor necrosis factor (TNF) blocker or another biologic if recommended for the diagnosis in the FDA-approved package label for the requested oral JAK inhibitor, OR B) Has a contraindication or an intolerance to TNF blockers or other biologics if recommended for the diagnosis in the FDA-approved package labeling for the requested oral JAK inhibitor, OR C) Has a current history (within the past 90 days) of being prescribed an oral JAK inhibitor?

☐ Yes ☐ No

Q79. Does the patient have glucocorticoid-dependent Still's disease?

☐ Yes ☐ No

Q80. Will the requested drug be used with the intent of discontinuing or decreasing the dose of the systemic glucocorticoid?

☐ Yes ☐ No

Q81. Does the patient have predominantly joint disease?

☐ Yes ☐ No

Q82. Does the patient have a history of one of the following: A) Therapeutic failure of a conventional non-biologic DMARD or B) A contraindication or intolerance to conventional non-biologic DMARDs?

☐ Yes ☐ No

Q83. Is the request for Arcalyst (rilonacept)?

☐ Yes ☐ No

Q84. Does the patient have a history of therapeutic failure, contraindication or intolerance of Kineret (anakinra) if approved or medically accepted for the beneficiary's diagnosis?

☐ Yes ☐ No

Q85. Does the patient have a current history of (within the past 90 days) of being prescribed Arcalyst (rilonacept)?

☐ Yes ☐ No

Q86. Is the request for Ilaris (canakinumab)?

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☐ Yes ☐ No

Q87. Does the patient have a history of therapeutic failure, contraindication or intolerance to Kineret (anakinra) if approved or medically accepted for the patient's diagnosis?

☐ Yes ☐ No

Q88. Does the patient have a current history of (within the past 90 days) of being prescribed Ilaris (canakinumab)?

☐ Yes ☐ No

Q89. Is this request for an infliximab product other than Avsola (infliximab-axxg)?

☐ Yes ☐ No

Q90. Does the patient have history of therapeutic failure, contraindication or intolerance of Avsola (infliximab-axxg) if approved or medically accepted for the diagnosis?

☐ Yes ☐ No

Q91. Does the patient have a current history of (within the past 90 days) of being prescribed infliximab?

☐ Yes ☐ No

Q92. Is the request for a non-preferred cytokine or cell adhesion molecule (CAM) antagonist?

☐ Yes ☐ No

Q93. Does the patient have a history of therapeutic failure, contraindication or intolerance to the preferred cytokine or cell adhesion molecule (CAM) antagonists approved or medically accepted for the diagnosis?

☐ Yes ☐ No

Q94. Has the patient been prescribed the same (within the past 90 days) the non-preferred cytokine or cell adhesion molecule (CAM) antagonist (does not apply to non-preferred brands when the therapeutically equivalent generic or interchangeable biosimilar is preferred, or to non-preferred generics or interchangeable biosimilars when the therapeutically equivalent or interchangeable brand is preferred)?

☐ Yes ☐ No

Q95. Has the patient experienced improvement in disease activity and/or level of functioning since initiating therapy with the requested cytokine and cell adhesion molecule (CAM) antagonist?

☐ Yes ☐ No

Q96. Is the requested drug prescribed by or in consultation with an appropriate specialist (e.g., gastroenterologist, dermatologist, rheumatologist, ophthalmologist, immunologist, genetic specialist, etc.)?

☐ Yes ☐ No

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Q97. Is the prescribed dose and duration of therapy consistent with the Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia or peer-reviewed medical literature?

☐ Yes ☐ No

Q98. Have all potential drug interactions been addressed by the prescriber (such as discontinuation of the interacting drug, dose reduction of the interacting drug or counseling of the beneficiary about the risks associated with the use of both medications when they interact)?

☐ Yes ☐ No

Q99. Is the patient currently taking any other cytokine or cell adhesion molecule (CAM) antagonist?

☐ Yes ☐ No

Q100. Is the requested drug associated with behavioral and/or mood changes as stated in the Food and Drug Administration (FDA)-approved package labeling?

☐ Yes ☐ No

Q101. Has the patient been evaluated for behavioral and mood changes as recommended in the Food and Drug Administration (FDA)-approved package labeling?

☐ Yes ☐ No

Q102. Additional Information:

Prescriber Signature

Date

Updated for 2023