

**CYTOKINE AND CAM ANTAGONISTS PRIOR AUTHORIZATION FORM** (form effective 1/1/20)

Prior authorization guidelines for **Cytokine and CAM Antagonists** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at <https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx>.

<input type="checkbox"/> New request	<input type="checkbox"/> Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:			Specialty:	
Contact's phone number:		NPI:	State license #:	
LTC facility contact/phone:		Street address:		
Beneficiary name:		Suite #:	City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:	

**CLINICAL INFORMATION**

<b>STARTER PACK</b> requested (name/strength):		<b>MAINTENANCE</b> product/packaging requested (name/strength):	
Quantity:	Duration:	Quantity:	Duration:
Directions:		Directions:	
Diagnosis ( <i>submit documentation</i> ):			Dx code ( <i>required</i> ):
Is the beneficiary currently being treated with the requested medication?		<input type="checkbox"/> Yes – date of last dose: _____ <i>Submit documentation.</i> <input type="checkbox"/> No	

**INITIAL requests**

Complete the sections below that are applicable to the beneficiary and this request and **SUBMIT DOCUMENTATION** for each item.

**DRUG**

- Requested drug is **NON-PREFERRED** drug:
  - Tried and failed or has a contraindication or intolerance to the preferred drugs in this class approved or medically accepted for the beneficiary's condition (*Refer to <https://papdl.com/preferred-drug-list> for a list of preferred and non-preferred drugs in this class.*)
- Requested drug is **ARCALYST (riloncept)** or **ILARIS (canakinumab)**:
  - Tried and failed or has a contraindication or intolerance to Kineret (anakinra) if approved or medically accepted for the diagnosis
- Requested drug is an **INFLIXIMAB PRODUCT OTHER THAN Renflexis (eg Remicade, Inflectra)**:
  - Tried and failed or has a contraindication or intolerance to Renflexis (infliximab) if approved or medically accepted for the diagnosis
- Requested drug is **COSENTYX (secukinumab)**:
  - Tried and failed or has a contraindication or intolerance to Humira (adalimumab) if approved or medically accepted for the diagnosis
- Requested drug is **OTEZLA (apremilast)** or **SILIQ (brodalumab)**:
  - Was evaluated for history of prior suicide attempt, bipolar disorder, or major depressive disorder

**DIAGNOSIS**

**ALL diagnoses:**

- vaccinated for hepatitis B
- screened for hepatitis B (surface antigen & core antibody)
- up-to-date with all age-appropriate immunizations
- screened for tuberculosis

**Ankylosing spondylitis & non-radiographic axial spondyloarthritis:**

- Tried and failed a 2-week trial of or has a contraindication or intolerance to 2 different oral NSAIDs

**Behçet's syndrome:**

- Has recurrent oral ulcers associated with Behçet's syndrome
- Tried and failed or has a contraindication or intolerance to a topical corticosteroid (e.g., triamcinolone dental paste)
- Tried and failed a 3-month trial of or has a contraindication or intolerance to colchicine at maximally tolerated doses

**Crohn's disease:**

- Has moderate-to-severe disease
- Has disease that is associated with high-risk or poor prognostic features
- Tried and failed or has a contraindication or intolerance to corticosteroids
- Tried and failed or has a contraindication or intolerance to immunomodulators (eg AZA, 6-MP, MTX)

**Familial Mediterranean fever:**

- Tried and failed a 3-month trial of or has a contraindication or intolerance to colchicine at maximally tolerated doses

**Giant cell arteritis:**

- Tried and failed or has a contraindication or intolerance to systemic glucocorticoids
- Is at high risk for glucocorticoid-related complications
- Has glucocorticoid-dependent disease

**Hidradenitis suppurativa:**

- Has Hurley stage II or stage III disease
- Tried and failed a 3-month trial of or has a contraindication or intolerance to topical clindamycin
- Tried and failed or has a contraindication or intolerance to systemic antibiotics (eg doxycycline, minocycline, tetracycline, clindamycin)

**Juvenile idiopathic arthritis:**

- Has systemic disease with active systemic features
- Has disease associated with high disease activity or poor prognostic features
- Tried and failed a 3-month trial of or has a contraindication or intolerance to conventional DMARDs (eg MTX)
- Has active sacroiliitis and/or enthesitis:**
  - Tried and failed a 2-week trial of or has a contraindication or intolerance to oral NSAIDs

**Plaque psoriasis:**

- Has a BSA of  $\geq 3\%$  that is affected
- Has involvement of critical areas of the body (e.g., skin folds, face, genitals)
- Has psoriasis that causes significant disability or impaired physical or mental functioning
- Tried and failed or has a contraindication or intolerance to topical corticosteroids
- Tried and failed or has a contraindication or intolerance to non-steroid topical medications (eg, anthralin, calcineurin inhibitor, tazarotene, etc)
- Tried and failed or has a contraindication or intolerance to ultraviolet light therapy
- Tried and failed a 3-month trial of or has a contraindication or intolerance to oral systemic medications (eg, MTX, cyclosporine, acitretin)

**Psoriatic arthritis:**

- Has severe disease
- Has comorbid moderate-to-severe nail psoriasis
- Has primarily axial disease and/or enthesitis:**
  - Tried and failed a 2-week trial of or has a contraindication or intolerance to 2 different oral NSAIDs
- Has predominantly peripheral disease**
  - Tried and failed an 8-week trial of or has a contraindication or intolerance to conventional DMARDs (eg AZA, leflunomide, MTX, SSZ)

**Rheumatoid arthritis:**

- Tried and failed a 3-month trial of or has a contraindication or intolerance to conventional DMARDs (eg AZA, leflunomide, MTX, etc)

**Ulcerative colitis:**

- Has moderate-to-severe disease
- Has disease associated with multiple poor prognostic factors
- Tried and failed or has a contraindication or intolerance to aminosalicylates (eg oral or rectal mesalamine, balsalazide, sulfasalazine)
- Tried and failed or has a contraindication or intolerance to corticosteroids
- Tried and failed or has a contraindication or intolerance to immunomodulators (eg AZA, cyclosporine, 6-MP, MTX)

**Uveitis (non-infectious):**

- Has comorbid juvenile idiopathic arthritis
- Has comorbid Behçet's syndrome
- Has corticosteroid-dependent disease
- Tried and failed or has a contraindication or intolerance to systemic, topical, intraocular, or periocular corticosteroids
- Tried and failed or has a contraindication or intolerance to conventional systemic immunosuppressives (eg AZA, MTX, MMF, etc)

**RENEWAL requests**

Submit documentation of the beneficiary's clinical response to the requested medication and appropriate monitoring as recommended in the drug package labeling.

**PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION**

**Prescriber Signature:**

**Date:**

**Confidentiality Notice:** The documents accompanying this telecopy may contain confidential information belonging to the sender. The information is intended only for the use of the individual named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any telecopy is strictly prohibited.