pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

CYTOKINE AND CAM ANTAGONISTS PRIOR AUTHORIZATION FORM *(form effective 1/9/2023)*

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.

☐New request ☐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:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

STARTER PACK requested (name/strength):		MAINTENANCE product/packaging requested (name/strength):	
Quantity per fill:	Refills:	Quantity per fill:	Refills:
Directions:		Directions:	
Diagnosis (*submit documentation*):		Dx code (*required*):	Beneficiary weight:
Is the beneficiary currently being treated with the requested medication?		☐Yes – date of last dose: _____ *Submit documentation.* ☐No	
Is the requested medication prescribed by or in consultation with a specialist (eg, rheumatologist, dermatologist, gastroenterologist, etc)?		☐Yes ☐No *If prescriber is not a specialist, submit documentation of consultation.*	

Complete all sections that apply to the beneficiary and this request.
Check all that apply and submit documentation for each item.

INITIAL requests

DRUG

1. Requested drug is NON-PREFERRED on the Statewide PDL:
   ☐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.)*
2. Requested drug is OTEZLA (apremilast) or SILIQ (brodalumab):
   ☐Was evaluated for history of prior suicide attempt, bipolar disorder, or major depressive disorder
3. Requested drug is an oral JAK inhibitor (eg, Olumiant [baricitinib], Rinvoq [upadacitinib], Xeljanz [tofacitinib]):
   ☐Tried and failed at least one TNF blocker or another biologic as recommended in the JAK inhibitor's package labeling
   ☐Has a contraindication or an intolerance to TNF blockers or other biologics as recommended in the JAK inhibitor's package labeling

DIAGNOSIS

1. ALL diagnoses:
   ☐Screened for hepatitis B virus infection (surface antigen, surface antibody, and core antibody)
   ☐Screened for tuberculosis

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2. Adult-onset Still's disease:
   - ☐ Has predominantly systemic disease:
     - ☐ Has steroid-dependent disease
     - ☐ Tried and failed or has a contraindication or an intolerance to systemic glucocorticoids
   - ☐ Has predominantly joint disease:
     - ☐ Tried and failed or has a contraindication or an intolerance to conventional DMARDs (eg, MTX)

3. Alopecia areata:
   - ☐ Has alopecia universalis
   - ☐ Has >50% scalp involvement or alopecia totalis
   - ☐ Has alopecia that causes significant disability or impaired physical, mental, or psychosocial functioning
   - ☐ Has a current episode of alopecia areata that has lasted at least 6 months

4. Ankylosing spondylitis & non-radiographic axial spondyloarthritis:
   - ☐ Tried and failed a 2-week trial of or has a contraindication or an intolerance to 2 different oral NSAIDs

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

6. Crohn's disease:
   - ☐ Has moderate-to-severe disease
   - ☐ Has disease that is associated with high-risk or poor prognostic features
   - ☐ Tried and failed to achieve remission with or has a contraindication or an intolerance to an induction course of corticosteroids
   - ☐ Tried & failed to maintain remission with or has a contraindication or an intolerance to conventional immunomodulators (eg, AZA, 6-MP, MTX)

7. Familial Mediterranean fever:
   - ☐ Tried and failed a 3-month trial of or has a contraindication or an intolerance to colchicine at maximally tolerated doses

8. Giant cell arteritis:
   - ☐ Tried and failed or has a contraindication or an intolerance to systemic glucocorticoids
   - ☐ Is at high risk for glucocorticoid-related complications
   - ☐ Has steroid-dependent disease

9. Hidradenitis suppurativa (HS):
   - ☐ Has Hurley stage II or stage III disease
   - ☐ Is a candidate for or has a history of surgical intervention for HS
   - ☐ Tried and failed a 3-month trial of or has a contraindication or an intolerance to topical clindamycin
   - ☐ Tried and failed or has a contraindication or an intolerance to systemic antibiotics (eg, doxycycline, minocycline, tetracycline, clindamycin)

10. Juvenile idiopathic arthritis:
    - ☐ Has systemic disease with active systemic features
    - ☐ Has disease associated with any of the following:
      - ☐ Positive anti-CCP antibodies
      - ☐ Positive rheumatoid factor
      - ☐ Presence of joint damage
      - ☐ At high risk of disabling joint damage
      - ☐ High disease activity
      - ☐ Involvement of high-risk joints (cervical spine, hip, wrist)
    - ☐ Tried and failed a 3-month trial of or has a contraindication or an 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 an intolerance to oral NSAIDs

11. Plaque psoriasis:
    - ☐ Has a BSA of ≥3% that is affected
    - ☐ Has involvement of critical areas of the body (eg, skin folds, face, genitals)

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- ☐ Has psoriasis that causes significant disability or impaired physical, mental, or psychosocial functioning
- ☐ Has moderate-to-severe nail disease
- ☐ Tried and failed a 4-week trial of or has a contraindication or an intolerance to topical corticosteroids
- ☐ Tried and failed an 8-week trial of or has a contraindication or an intolerance to non-steroid topical medications (eg, anthralin, calcineurin inhibitor, tazarotene, etc)
- ☐ Tried and failed or has a contraindication or an intolerance to ultraviolet light therapy
- ☐ Tried & failed a 3-month trial of or has a contraindication/intolerance to conventional systemic medications (eg, MTX, cyclosporine, acitretin)

12. Psoriatic arthritis:
    - ☐ Tried and failed an 8-week trial of or has a contraindication or an intolerance to conventional DMARDs (eg, AZA, leflunomide, MTX, SSZ)
    - ☐ Has predominantly axial disease, dactylitis, and/or enthesitis
    - ☐ Has severe disease
    - ☐ Has comorbid moderate-to-severe nail psoriasis
    - ☐ Has comorbid active inflammatory bowel disease
13. Rheumatoid arthritis:
    - ☐ Tried and failed a 3-month trial of or has a contraindication or an intolerance to conventional DMARDs (eg, AZA, leflunomide, MTX, etc)
14. Sarcoidosis:
    - ☐ Tried and failed or has a contraindication or an intolerance to systemic glucocorticoids
    - ☐ Has steroid-dependent disease
    - ☐ Tried and failed or has a contraindication or an intolerance to a conventional DMARD (eg, AZA, leflunomide, MTX, mycophenolate)
15. Ulcerative colitis:
    - ☐ Has moderate-to-severe disease
    - ☐ Has disease associated with multiple poor prognostic factors
    - ☐ Tried and failed to achieve remission with or has a contraindication or an intolerance to an induction course of corticosteroids
    - ☐ Tried and failed to maintain remission with or has a contraindication or an intolerance to conventional immunomodulators (eg, AZA, cyclosporine, 6-MP, MTX)
16. Uveitis (non-infectious):
    - ☐ Has comorbid juvenile idiopathic arthritis
    - ☐ Has comorbid Behçet's syndrome
    - ☐ Has steroid-dependent disease
    - ☐ Tried and failed or has a contraindication or an intolerance to systemic, topical, intraocular, or periocular corticosteroids
    - ☐ Tried and failed or has a contraindication or an intolerance to conventional systemic immunosuppressives (eg, AZA, MTX, MMF, etc)
17. Other diagnosis: _____
    - ☐ List other treatments tried (including start/stop dates, dose, outcomes): _____

      _____

RENEWAL requests

- ☐ Experienced an improvement in disease severity or level of functioning since starting therapy with the requested medication
- ☐ Is prescribed an increased dose or more frequent administration of the requested medication
- ☐ Requested drug is OTEZLA (apremilast) or SILIQ (brodalumab):
  - ☐ Was recently reevaluated for behavioral and mood changes

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

Prescriber Signature:	Date: