



Fax completed prior authorization request form to 855-247-3677 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at [www.mercycareaz.org/providers/rbha-forproviders/pharmacy](http://www.mercycareaz.org/providers/rbha-forproviders/pharmacy)

## Cytokines and Cell Adhesion Molecule (CAM) Antagonists Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

**REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis**

### Member Information

Member Name (first & last):	Date of Birth:	Gender:		Height:
		<input type="checkbox"/> Male	<input type="checkbox"/> Female	
Member ID:	City:	State:		Weight:

### Prescribing Provider Information

Provider Name (first & last):	Specialty:	NPI#	DEA#
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone	Office Fax:	

### Dispensing Pharmacy Information

Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:
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### Requested Medication Information

Preferred Agents:	<input type="checkbox"/> Enbrel	<input type="checkbox"/> Humira	<input type="checkbox"/> Otezla	<input type="checkbox"/> Xeljanz IR		
Non-Preferred Agents:	<input type="checkbox"/> Actemra	<input type="checkbox"/> Arcalyst	<input type="checkbox"/> Cosentyx	<input type="checkbox"/> Taltz	<input type="checkbox"/> Ilaris	<input type="checkbox"/> Ilumya
	<input type="checkbox"/> Kineret	<input type="checkbox"/> Siliq	<input type="checkbox"/> Orencia	<input type="checkbox"/> Renflexis	<input type="checkbox"/> Tremfya	<input type="checkbox"/> Tysabri
	<input type="checkbox"/> Olumiant	<input type="checkbox"/> Remicade	<input type="checkbox"/> Xeljanz XR	<input type="checkbox"/> Cimzia	<input type="checkbox"/> Skyrizi	<input type="checkbox"/> Simponi Aria
	<input type="checkbox"/> Simponi	<input type="checkbox"/> Stelara	<input type="checkbox"/> Inflectra	<input type="checkbox"/> Other, specify:		

Medication request is NOT for an FDA- approved, or compendia-supported diagnosis (circle one): Yes      No	Diagnosis:	<input type="checkbox"/> ICD-10 Code:
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Are there any contraindications to formulary medications? (if yes, specify):	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> New request	<input type="checkbox"/> Continuation of therapy
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Directions for Use:	Strength:	Dosage Form:	
	Quantity:	Day Supply:	Duration of Therapy/Use:

What medication(s) has the member tried and failed for this diagnosis? Please specify below.

### Turn-Around Time for Review

<input type="checkbox"/> Standard – (24 hours)	<input type="checkbox"/> <b>Urgent</b> – waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision.
Signature: _____	

### Clinical Information

#### General Authorization Criteria

Is member on another Cytokine or Cell Adhesion Molecule (CAM) Antagonist?	<input type="checkbox"/> Yes	<input type="checkbox"/> No				
Is request for Anti-Tumor Necrosis Factor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does member have NYHA class III OR IV CHF?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Is request for Anti-Tumor Necrosis Factors such as Stelara, Xeljanz, Xeljanz XR, Kineret, Actemra, Ilaris OR Orencia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No				
Was a screen completed for Hepatitis B?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does member have active OR chronic Hepatitis B?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If member has active OR chronic Hepatitis B, is member receiving appropriate antiviral treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A			
Was member evaluated AND given appropriate vaccinations, as recommended per CDC, for risk factors?	<input type="checkbox"/> Yes	<input type="checkbox"/> No				

Was member screened for TB?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If screening was positive for latent TB, was treatment received for latent TB?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Is request for Entyvio OR Tysabri?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is use Monotherapy AND not in combination with antineoplastic, immunosuppressive OR immunomodulating agents (AZA, 6-MP, cyclosporine, MTX, TNF inhibitors)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
<b>Additional Criteria Based on Indication:</b>						
<input type="checkbox"/> <b>Rheumatoid Arthritis</b>						
Was there inadequate response to 3-month trial of MTX?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was there intolerance OR contraindication to MTX?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Were SSZ, LEF or HCQ used due to intolerance OR contraindication to MTX?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Will requested medication be used concurrently with MTX or another non-biologic DMARD such as SSZ, LEF or HCQ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> <b>Systemic Juvenile Idiopathic Arthritis</b>						
Does member have ACTIVE SYSTEMIC FEATURES such as fever, evanescent rash, lymphadenopathy, hepatomegaly, splenomegaly OR serositis? (circle one):			Is synovitis in <u>ONE OR MORE JOINTS</u> despite 3 months treatment with <u>MTX OR LEF</u> ? (circle one):			
Yes      No			Yes      No			
Check if ONE of the following apply:	<input type="checkbox"/> There are ACTIVE SYSTEMIC FEATURES (fever, evanescent rash, lymphadenopathy, hepatomegaly, splenomegaly OR serositis) AND synovitis is in at least <u>ONE JOINT</u> .					
	<input type="checkbox"/> There are NO ACTIVE SYSTEMIC FEATURES (fever, evanescent rash, lymphadenopathy, hepatomegaly, splenomegaly OR serositis) AND synovitis is in <u>ONE OR MORE JOINTS</u> despite 3 months treatment with <u>MTX OR LEF</u> .					
There are ACTIVE SYSTEMIC FEATURES (fever, evanescent rash, lymphadenopathy, hepatomegaly, splenomegaly, or serositis) (circle one):			Synovitis is in ONE OR MORE JOINTS despite ONE-month treatment with Kineret OR Actemra AND MTX OR LEF (circle one):			
Yes      No			Yes      No			
<input type="checkbox"/> <b>Polyarticular Juvenile Idiopathic Arthritis</b>						
Was there inadequate response to 3-months trial with MTX?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was there an intolerance OR contraindication to MTX?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Was there trial with SSZ OR LEF for 3 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A			
<input type="checkbox"/> <b>Oligoarticular Juvenile Idiopathic Arthritis</b>						
Is disease duration > 6 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was there documented inadequate response OR intolerable side effect with 2 NSAIDs?	<input type="checkbox"/> Yes, indicate drug:		<input type="checkbox"/> No
Was there contraindication to NSAIDs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Was there inadequate response OR intolerable side effect to 3-month trial with MTX?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Was there documented trial of LEF OR SSZ for 3 months?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	
<input type="checkbox"/> <b>Cryopyrin-Associated Periodic Syndromes</b>						
Indicate if ONE of the following subtypes is present:	<input type="checkbox"/> Familial Cold Auto Inflammatory Syndrome		<input type="checkbox"/> Muckle-Wells syndrome		<input type="checkbox"/> Neonatal onset multi-system inflammatory disease	
Was there 3-months trial with Kineret?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	
<input type="checkbox"/> <b>Familial Mediterranean Fever</b>						
Was there inadequate response, intolerance OR contraindication to colchicine at MAX indicated dose?			<input type="checkbox"/> Yes	<input type="checkbox"/> No		
<input type="checkbox"/> <b>Giant Cell Arteritis</b>						
Was there inadequate response with glucocorticoids (prednisone, methylprednisolone)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was there intolerance OR contraindication to glucocorticoids?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If member had intolerance OR contraindication to glucocorticoids, was there TRIAL with MTX OR cyclophosphamide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Will medication be used in combination with tapering course of glucocorticoids	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> <b>Ankylosing Spondylitis</b>						
Was there inadequate response to ONE-month trial of TWO NSAIDs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is there contraindication OR intolerance to oral NSAIDs?		<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A
<input type="checkbox"/> <b>Psoriatic Arthritis</b>						
Does member have ACTIVE Psoriatic Arthritis?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was there inadequate response to 3-months trial with MTX?	
Was there intolerance OR contraindication to MTX?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Was there 3-month trial of SSZ OR LEF?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Is disease predominantly AXIAL OR ACTIVE ENTHESITIS / DACTYLITIS?				<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Was there inadequate response to ONE-month trial of 2 NSAIDs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was there contraindication OR intolerance to oral NSAIDs?		<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A
<input type="checkbox"/> <b>Plaque Psoriasis</b>						
Was there inadequate response to MTX OR cyclosporine for ≥3 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was there intolerance OR contraindication to MTX OR cyclosporine for ≥3 months?		<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A
Is >10% BSA affected?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is <10% BSA affected BUT involves sensitive areas such as hands, feet, face OR genitals?		<input type="checkbox"/> Yes	<input type="checkbox"/> No

Is Psoriasis Area and Severity Index score >10?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was phototherapy PUVA, UVB ineffective?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
For Siliq ONLY:	Is there history of a prior suicide attempt, bipolar disorder OR depressive disorder?		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
	Was a mental health evaluation completed by prescriber OR psychiatrist?		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
<input type="checkbox"/> <b>Ulcerative Colitis</b>						
<input type="checkbox"/> STEROID DEPENDENT	A relapse occurred within 3-months of stopping glucocorticoids (circle one): Yes                      No		There is inability to taper steroids to acceptable dose after 3 months W/O having symptom recurrence:(circle one): Yes                      No			
<input type="checkbox"/> STEROID REFRACTORY	Inadequate response OR intolerable side effect to IV glucocorticoids after 7-10 days (circle one): Yes                      No		Inadequate response OR intolerable side effect to oral prednisone ≥40mg per day after 30 days (circle one): Yes                      No			
<input type="checkbox"/> <b>Crohn's Disease</b>						
<input type="checkbox"/> STEROID DEPENDENT	A relapse occurred within 3-months of stopping glucocorticoids (circle one): Yes                      No		There was inadequate response OR intolerable side effect, with 3-month trial of 6-MP OR AZA OR injectable MTX (circle one): Yes                      No			
	There is inability to taper steroids to acceptable dose after 3 months W/O having symptom recurrence (circle one): Yes                      No		There was contraindication to 6-MP, AZA, AND injectable MTX (circle one): Yes                      No			
<input type="checkbox"/> STEROID REFRACTORY	There was inadequate response OR intolerable side effect to IV glucocorticoids after 7-10 days (circle one): Yes                      No		There was inadequate response OR intolerable side effect to oral prednisone ≥40mg per day after 30 days (circle one): Yes                      No			
<input type="checkbox"/> <b>Hidradenitis Suppurativa (Acne Inversa)</b>						
Does member have moderate to severe disease (Hurley stage II-III)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was there trial AND failure of 90-day treatment with oral antibiotics (doxycycline, minocycline OR clindamycin with rifampin)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> <b>Behçet's Disease</b>						
Does member have ACTIVE RECURRENT oral ulcers?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was there trial AND failure with ONE Non-Biologic DMARD (MTX, LEF, SSZ OR HCQ)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> <b>Uveitis</b>						
Was intermediate, posterior OR pan uveitis caused by infection?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	There was inadequate response OR intolerable side effect with following:	<input type="checkbox"/> cyclosporine	<input type="checkbox"/> tacrolimus	<input type="checkbox"/> Corticosteroids
				<input type="checkbox"/> MTX	<input type="checkbox"/> AZA	<input type="checkbox"/> MMF
Are medications such as corticosteroids, MTX, AZA, MMF, cyclosporine, AND tacrolimus are NOT appropriate?				<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> <b>Cytokine Release Syndrome</b>						
Is diagnosis grade 3 OR 4, severe OR life-threatening due to chimeric antigen receptor-T cell therapy?				<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records</b>						

**Signature affirms that information given on this form is true and accurate and reflects office notes.**

**Prescribing Provider's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Please note: Incomplete forms or forms without the chart notes will be returned**

Office notes, labs, and medical testing relevant to the request that show medical justification are required.  
Standard turnaround time is 24 hours. You can call 800-564-5465 to check the status of a request.