United Healthcare Community Plan

Cytokine & CAM Antagonists: IL-17 Inhibitors - Washington

Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**

This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.

Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Provider Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL for a list of preferred alternatives

United Healthcare Community Plan

Cytokine & CAM Antagonists: IL-17 Inhibitors - Washington
Prior Authorization Request Form

Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

1. Is this request for a continuation of therapy? ☐ Yes ☐ No
   If yes, does patient have clinical documentation demonstrating disease stability or a positive clinical response? ☐ Yes ☐ No

2. Is this prescribed by, or in consultation with, any of the following? Check all that apply:
   ☐ Dermatologist ☐ Rheumatologist ☐ Other. Specify: _____

3. Will the requested medication be used in combination with another Cytokine and CAM medication?
   ☐ Yes ☐ No

4. If request is non-preferred, has patient had treatment with one or more preferred Cytokine and CAM medications on the Apple Health Preferred Drug List (AHPDL) that was ineffective, contraindicated or not tolerated?

☐ Yes. List each medication and duration of trial:

Medication Name: _____ Duration: _____
Medication Name: _____ Duration: _____
Medication Name: _____ Duration: _____

☐ No. Explain why a preferred product(s) have not been tried: _____

5. What is patient current weight: _____kg Date taken: _____

6. Indicate patient's diagnosis and answer the associated questions as indicated:
   ☐ Ankylosing Spondylitis (questions 7-11)
   ☐ Enthesitis-related arthritis (questions 12 -13)
   ☐ Hidradenitis Suppurativa (HS) (questions 14 -17)
   ☐ Non-radiographic axial spondyloarthritis (questions 7-11)
   ☐ Plaque Psoriasis (questions 18 - 22)
   ☐ Psoriatic Arthritis (PsA) (questions 23 - 26)

For diagnosis of Ankylosing Spondylitis or Non-radiographic axial spondyloarthritis:

7. Does patient have high disease activity as indicated by one of the following?

☐ Bath Ankylosing Disease Activity Index (BASDAI) score of at least 4
☐ Ankylosing Spondylitis Disease Activity Score (ASDAS) score of at least 2.1

8. Has patient had treatment with at least two different NSAIDs that has been ineffective, contraindicated or not tolerated [minimum trial of four weeks]? ☐ Yes ☐ No

9. Has patient's disease manifested as one of the following?

☐ Axial disease ☐ Peripheral arthritis

10. Has patient had treatment with at least one non-Cytokine and CAM disease-modifying antirheumatic drug (DMARD) that has been ineffective, contraindicated or not tolerated [minimum trial of 3 months]?

☐ Yes ☐ No

11. **For continuation of therapy:** Has documentation been submitted demonstrating disease stability or a positive clinical response (e.g., decrease in BASDAI or ASDAS score)? ☐ Yes ☐ No

For diagnosis of Enthesitis-related arthritis

12. Has patient had treatment with at least one non-Cytokine and CAM DMARD (e.g., methotrexate, sulfasalazine, leflunomide, hydroxychloroquine, azathioprine, cyclosporine) that has been ineffective, unless all are contraindicated, or not tolerated [minimum trial of 3 months]? ☐ Yes ☐ No

13. **For continuation of therapy:** Has documentation been submitted demonstrating disease stability or a positive clinical response (e.g., improvement in joint pain, swelling, activities of daily living, reduction in diseases flares, etc.)? ☐ Yes ☐ No

For diagnosis of Hidradenitis Suppurativa (HS)

14. Does patient have presence of inflammatory nodules and/or abscesses? ☐ Yes ☐ No

15. Does patient have diagnosis of one of the following?
☐ Hurley Stage III (severe) disease ☐ Hurley Stage II (moderate) disease

16. Does patient have a history of failure, contraindication, or intolerance to at least one oral antibiotic (i.e., doxycycline, minocycline, tetracycline, clindamycin + rifampin, etc.) [minimum trial of 3 month trial]
☐ Yes ☐ No

17. **For continuation of therapy:** Has documentation been submitted demonstrating disease stability or a positive clinical response (e.g., reduction in abscess or inflammatory nodules)? ☐ Yes ☐ No

For diagnosis of Plaque Psoriasis

18. Does patient have presence of ongoing disease for greater than 6 months? ☐ Yes ☐ No

19. Please indicate the following for patient:
☐ Disease affects at least 10% body surface area ☐ Disease affects the face, ears, hands, feet, or genitalia

20. Have baseline assessments been submitted (e.g., body surface area (BSA), Psoriasis Area and Severity Index (PASI), Psoriasis Physician's Global Assessment (PGA), itch numeric rating scale, etc.)?
☐ Yes ☐ No

21. Has patient had a history of failure, contraindication, or intolerance to the following? Check all that apply:
☐ Phototherapy (UVB or PUVA) [minimum trial of 12 weeks]
☐ Treatment with at least one non-Cytokine and CAM DMARD (e.g., methotrexate, cyclosporine, acitretin, azathioprine, etc.) [minimum trial of 12 weeks]

22. **For continuation of therapy:** Has documentation been submitted demonstrating disease stability or a positive clinical response (e.g., improvement in BSA, PSAI, Psoriasis PGA, itch numeric rating scale)?
☐ Yes ☐ No

For diagnosis of Psoriatic Arthritis

23. Has patient had treatment with at least one non-Cytokine and CAM disease-modifying antirheumatic drug (DMARD) that has been ineffective, contraindicated or not tolerated [minimum trial of 3 months]?
☐ Yes ☐ No

24. Does patient have presence of active, severe disease indicated by provider assessment?
☐ Yes ☐ No

25. Does patient have presence of any of the following? Check all that apply:
☐ Erosive disease
☐ Elevated C-reactive protein (CRP) or erythrocyte sedimentation rate (ESR)
☐ Long-term damage interfering with function (e.g., joint deformities, vision loss)
☐ Major impairment of quality of life due to high disease activity at many sites (including dactylitis, enthesitis) or functionally limiting arthritis at a few sites.

26. **For continuation of therapy:** Has documentation been submitted demonstrating disease stability or a positive clinical response (e.g., improvement in joint pain, swelling, activities of daily living, reduction in diseases flares, etc.)? ☐ Yes ☐ No

CHART NOTES ARE REQUIRED WITH THIS REQUEST		
Prescriber signature	Prescriber specialty	Date