Cytokine and CAM Antagonists: T-Lymphocyte 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

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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 ☐ Hematologist ☐ Oncologist
   ☐ 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:
   ☐ Graft Versus Host Disease (questions 7-9)
   ☐ Polyarticular Juvenile Idiopathic Arthritis (questions 10 – 11)
   ☐ Psoriatic Arthritis (PsA) (questions 12 - 15)
   ☐ Rheumatoid Arthritis (questions 16 - 18)

For diagnosis of Graft Versus Host Disease:

7. **If patient has received a hematopoietic stem cell transplant (HSCT):** Indicate the following for patient. Check all that apply:

☐ Requested drug will be used as additional therapy in combination with corticosteroids for chronic GVHD
☐ Patient has no response (e.g., steroid-refractory disease) to first-line therapy options

8. **If patient is undergoing a hematopoietic stem cell transplant (HSCT) from a matched or 1 allele-mismatched unrelated-donor:** Indicate the following for patient. Check all that apply:

☐ Requested drug will be used for prophylaxis of acute graft versus host disease (aGVHD)
☐ Requested drug will be used in combination with a calcineurin inhibitor and methotrexate
☐ Patient will receive antiviral prophylactic treatment for Epstein-Barr Virus (EBV) reactivation and prophylaxis will continue for 6 months post-transplantation

9. **If patient received the requested medication previously,** indicate the dates and duration of treatment:

Date(s) received: _____ Duration of treatment: _____

For diagnosis of Polyarticular Juvenile Idiopathic Arthritis

10. 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

11. **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 Psoriatic Arthritis

12. 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

13. Does patient have presence of active, severe disease indicated by provider assessment?

☐ Yes ☐ No

14. 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.

15. **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 Rheumatoid Arthritis (RA)

16. Have baseline assessments been submitted (e.g., Disease Activity Score for 28 joints (DAS28) with the CRP, DAS28 with ESR, Simplified Disease Activity Index (SDAI), Clinical Disease Activity Index (CDAI), Routine Assessment of Patient Index Data 3 (RAPID3), Patient Activity Scale (PAS) II? ☐ Yes ☐ No

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

18. **For continuation of therapy:** Has documentation been submitted demonstrating disease stability or a positive clinical response (e.g. improvement in DAS28 with CRP/ESR, SDAI, CDAI, RAPID3, PAS II scores)?

☐ Yes ☐ No

CHART NOTES ARE REQUIRED WITH THIS REQUEST

Prescriber signature	Prescriber specialty	Date