Reset Form Print Form

Prior Authorization Form
Immunomodulators

Fax this form to: 1-800-424-3260

A fax cover sheet is not required.

Instructions: Please fill out all applicable sections on all pages completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the prior authorization). **Information contained in this form is Protected Health Information under HIPAA**.

☐ **NON-URGENT** ☐ **EXIGENT CIRCUMSTANCES**

MEMBER INFORMATION

Member's Last Name:

Member's First Name:

Member's Identification Number:

Date of Birth: ___ – ___ – ____

PRESCRIBER INFORMATION

Prescriber's Last Name:

Prescriber's First Name:

National Provider Identifier (NPI) Number:

DEA Number:

Office Phone Number: ___ – ___ – ____

Office Fax Number: ___ – ___ – ____

CLINICAL CRITERIA

1. What medication is being requested? _____
2. What is the diagnosis for the medication? _____
3. Has the member been screened to rule out the presence of latent tuberculosis (TB) infection prior to initiating treatment?
   ☐ Yes ☐ No
4. Has the member been evaluated and screened for the presence of hepatitis B virus?
   ☐ Yes ☐ No
5. Does the member have any active infections, including clinically important localized infections?
   ☐ Yes ☐ No
6. Will the member receive any live vaccines while on therapy?
   ☐ Yes ☐ No

(Form continued on next page.)

Member's Last Name:

Member's First Name:

7. Will the member be taking this with any other tumor-necrosis factor (TNF) inhibitor or biological disease-modifying antirheumatic drugs (DMARD) (e.g., Orencia®, Kineret®, Xeljanz®, Actemra®)?
   ☐ Yes ☐ No
   If **Yes**, list agent(s):
   _____
8. Will the member be taking this with a non-biologic DMARD (e.g., methotrexate, hydroxychloroquine, sulfasalazine, cyclosporine, leflunomide)?
   ☐ Yes ☐ No
   If **Yes**, list agent(s):
   _____
9. Has the physician assessed baseline disease severity utilizing an objective measure/tool?
   ☐ Yes ☐ No
   If **Yes**, what objective tool was used:
   _____
10. Is the requested medication being prescribed by or in consultation with a specialist?
    ☐ Yes ☐ No
    If **Yes**, provide specialty:
    _____
11. List **all** medications the member has tried and failed that relate to this request (include the dates used):

    Medication: _____ Dates Used: _____

    Medication: _____ Dates Used: _____

    Medication: _____ Dates Used: _____

    Medication: _____ Dates Used: _____

    Medication: _____ Dates Used: _____
12. Does the member have a documented moderate to severe active form of the disease?
    ☐ Yes ☐ No

For Xeljanz® Only:

1. Will the member take Xeljanz® in combination with a potent immunosuppressant (e.g., azathioprine or cyclosporine) or with other Janus kinase (JAK) inhibitors (e.g., Olumiant®)?
   ☐ Yes ☐ No

For Stelara® Only:

1. What is the member's weight? _____

(Form continued on next page.)

Member's Last Name:

Member's First Name:

Diagnosis of Plaque Psoriasis (PsO) (Otezla®)

1. Does the member have plaques covering ≥ 10% of their body surface area (BSA), palmoplantar involvement, or severe scalp psoriasis?
   ☐ Yes ☐ No

Diagnosis of Severe Hidradenitis Suppurativa

1. Does the member have Hurley stage II or III?
   ☐ Yes ☐ No
2. Does the member have at least 3 abscesses or inflammatory nodules?
   ☐ Yes ☐ No

Diagnosis of Neonatal-onset Multisystem Inflammatory Disease (Kineret®)

1. Was the member diagnosed with **one** of the following: NLRP-3 (nucleotide-binding domain, leucine-rich family (NLR), pyrin domain containing 3-gene (NLRP-3) gene mutation, cold-induced autoinflammatory syndrome-1 (CIAS1)?
   ☐ Yes ☐ No
   If **Yes**, specify which:
   _____
2. Does the member have **two** of the following: urticaria-like rash, cold/stress triggered episodes, sensorineural hearing loss, musculoskeletal symptoms, chronic aseptic meningitis, or skeletal abnormalities?
   ☐ Yes ☐ No
3. Does the member have elevated acute phase reactants (e.g., erythrocyte sedimentation rate [ESR], C-reactive protein [CRP], serum amyloid A [SAA])?
   ☐ Yes ☐ No

Diagnosis of Uveitis

1. Does the member have non-infectious uveitis?
   ☐ Yes ☐ No
2. Does the member have intermediate, posterior, or panuveitis?
   ☐ Yes ☐ No

Renewal Requests

Note: Use of free goods or samples does not qualify as established therapy for renewal.

1. Has the member had positive clinical response with the medication? (Provide details on disease response.)
   ☐ Yes ☐ No

For diagnosis of **plaque psoriasis:**

2. Has the member shown any of the following?
   ☐ Reduction in BSA involvement from baseline
   ☐ Improvement in symptoms (e.g., pruritus, inflammation) from baseline

(Form continued on next page.)

 MHID: MRXCOM05_01

Member's Last Name:

Member's First Name:

Provide any other information pertinent to this PA request:

☐ **Attachments**

Note: If approved, compliance with therapy is required. Authorizations will be terminated for members who are noncompliant with therapy.

_____ _____

Prescriber Signature (Required) ***Date***

(By signature, the Physician confirms the above information is accurate and verifiable by patient records.)

Fax this form to: 1-800-424-3260

Mail requests to:
Magellan Rx Management Prior Authorization Program
c/o Magellan Health, Inc.
4801 E. Washington Street
Phoenix, AZ 85034
Phone: 1-800-424-3312

