# Alabama Medicaid Pharmacy
# DMARD/Biological Injectables Prior Authorization Request Form



FAX: (800) 748-8118
Phone: (800) 748-0130

Fax or Mail to
Health Information Designs

P. O. Box 3250
Auburn, AL 36831-3250

## PATIENT INFORMATION

Patient name _____ Patient Medicaid # _____

Patient DOB _____ Patient phone # with area code _____

## PRESCRIBER INFORMATION

Prescriber name _____ NPI # _____ License # _____

Phone # with area code _____ Fax # with area code _____

Address (Optional) _____

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I will be supervising the patient's treatment. Supporting documentation is available in the patient record.

_____ _____
Prescribing Provider Signature Date

## CLINICAL INFORMATION

Drug Requested: ☐ Actemra ☐ Arava ☐ Avsola ☐ Cimzia ☐ Cosentyx ☐ Cosentyx ☐ Duplicate ☐ Enbrel ☐ Entyvio ☐ Fasenra ☐ Humira ☐ Ilaris ☐ Inflectra ☐ Kevzara ☐ Kineret ☐ Lupkynis ☐ Myorisol ☐ Nucala ☐ Olumiant ☐ Orencia ☐ Otezla ☐ Remicade ☐ Renflexis ☐ Rinvoq ☐ Silig ☐ Simponi ☐ Skyrizi ☐ Stelara ☐ Taltz ☐ Tremfya ☐ Xeljanz

**Pharmacy Claim Request:**

NDC/J Code _____ Strength _____ Qty _____ Days' Supply _____

Current weight: _____ ICD-10 Code _____ Number of Refills _____

**Physician Administered/Medical Claim Request:**

J Code _____ Strength _____ J Code Units _____ Days' Supply _____

Current weight: _____ ICD-10 Code _____

**Please check the appropriate diagnosis below and answer diagnosis specific questions:**

☐ **Ankylosing Spondylitis (AS) or Non-Radiographic Axial Spondyloarthritis (nr-AxSpA)**
- Is therapy approved by a board certified rheumatologist? ☐ Yes ☐ No
- Has the patient failed a 3 month treatment trial with at least 2 NSAIDs? If yes, attach documentation. ☐ Yes ☐ No
- For symptomatic peripheral arthritis, has the patient failed a 30-day treatment trial with at least one nonbiologic DMARD? If yes, attach documentation. ☐ Yes ☐ No

☐ **Atopic Dermatitis**
- Is therapy approved by a board-certified dermatologist? ☐ Yes ☐ No
- Has the patient failed a 6-month treatment trial with at least one topical prescription treatment within the past 12 months? Include past therapies _____ ☐ Yes ☐ No

☐ **Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)**
- Does the patient have a diagnosis of CRSwNP despite prior sino-nasal surgery or treatment with, or who are ineligible to receive or were intolerant to, systemic corticosteroids in the past 2 years? ☐ Yes ☐ No
- Is the patient currently taking an intranasal corticosteroid? ☐ Yes ☐ No

☐ **Crohn's Disease (CD) or Ulcerative Colitis (UC)**
- Is therapy approved by a board certified gastroenterologist? ☐ Yes ☐ No
- Has the patient failed a 30-day treatment trial with at least one or more conventional therapies? If yes, attach documentation. ☐ Yes ☐ No
- For Entyvio or Stelara, has the patient failed a 30-day treatment trial with at least one of the following: a tumor necrosis factor blocker, immunomodulator, or corticosteroid? If yes, attach documentation. ☐ Yes ☐ No

☐ **Cryopyrin-Associated Periodic Syndrome**
- Is there a diagnosis of cryopyrin-associated periodic syndrome/neonatal-onset multisystem inflammatory disease? ☐ Yes ☐ No

☐ **Cytokine Release Syndrome**
- Is there a diagnosis of chimeric antigen receptor (CAR) T cell-induced severe or life threatening cytokine release syndrome? ☐ Yes ☐ No

☐ **Deficiency of Interleukin 1 Receptor Antagonist**
- Does the patient have a diagnosis of Deficiency of Interleukin 1 Receptor Antagonist? ☐ Yes ☐ No