

Immune Modulating Therapy Prior Authorization Request Form (Page 1 of 6)

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Member Information (required)			Provider Information (required)																						
Member Name:			Provider Name:																						
Insurance ID#:			NPI#:		Specialty:																				
Date of Birth:			Office Phone:																						
Street Address:			Office Fax:																						
City:	State:	Zip:	Office Street Address:																						
Phone:			City:	State:	Zip:																				
Medication Information (required)																									
Medication Name:			Strength:		Dosage Form:																				
<input type="checkbox"/> Check if generic substitution is acceptable			Directions for Use:																						
<input type="checkbox"/> Check if request is for continuation of therapy																									
Clinical Information (required)																									
<p>Select the diagnosis below:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top; padding: 2px;"><input type="checkbox"/> Ankylosing spondylitis</td> <td style="width: 50%; vertical-align: top; padding: 2px;"><input type="checkbox"/> Psoriatic arthritis</td> </tr> <tr> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Crohn's disease</td> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Recurrent Pericarditis</td> </tr> <tr> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Cryopyrin-associated periodic syndromes (CAPS)</td> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Rheumatoid arthritis (RA)</td> </tr> <tr> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Deficiency of Interleukin-1 Receptor Antagonist (DIRA)</td> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Systemic juvenile idiopathic arthritis (SJIA)</td> </tr> <tr> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Giant cell arteritis</td> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Systemic sclerosis-associated interstitial lung disease (SSc-ILD)</td> </tr> <tr> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Hidradenitis suppurativa</td> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Ulcer of the mouth associated with Behcet's syndrome</td> </tr> <tr> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Non-radiographic axial spondyloarthritis (nr-axSpA)</td> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Ulcerative colitis</td> </tr> <tr> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Plaque psoriasis</td> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Uveitis</td> </tr> <tr> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Polyarticular juvenile idiopathic arthritis (PJIA)</td> <td></td> </tr> <tr> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Other diagnosis: _____</td> <td style="vertical-align: top; padding: 2px;">ICD-10 Code(s): _____</td> </tr> </table>						<input type="checkbox"/> Ankylosing spondylitis	<input type="checkbox"/> Psoriatic arthritis	<input type="checkbox"/> Crohn's disease	<input type="checkbox"/> Recurrent Pericarditis	<input type="checkbox"/> Cryopyrin-associated periodic syndromes (CAPS)	<input type="checkbox"/> Rheumatoid arthritis (RA)	<input type="checkbox"/> Deficiency of Interleukin-1 Receptor Antagonist (DIRA)	<input type="checkbox"/> Systemic juvenile idiopathic arthritis (SJIA)	<input type="checkbox"/> Giant cell arteritis	<input type="checkbox"/> Systemic sclerosis-associated interstitial lung disease (SSc-ILD)	<input type="checkbox"/> Hidradenitis suppurativa	<input type="checkbox"/> Ulcer of the mouth associated with Behcet's syndrome	<input type="checkbox"/> Non-radiographic axial spondyloarthritis (nr-axSpA)	<input type="checkbox"/> Ulcerative colitis	<input type="checkbox"/> Plaque psoriasis	<input type="checkbox"/> Uveitis	<input type="checkbox"/> Polyarticular juvenile idiopathic arthritis (PJIA)		<input type="checkbox"/> Other diagnosis: _____	ICD-10 Code(s): _____
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<p>Prescriber's Specialty:</p> <p>Select if the requested medication is recommended by one of the following specialists:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;"><input type="checkbox"/> Dermatologist</td> <td style="width: 33%;"><input type="checkbox"/> Ophthalmologist</td> <td style="width: 33%;"><input type="checkbox"/> Other: _____</td> </tr> <tr> <td><input type="checkbox"/> Gastroenterologist</td> <td><input type="checkbox"/> Rheumatologist</td> <td></td> </tr> </table>						<input type="checkbox"/> Dermatologist	<input type="checkbox"/> Ophthalmologist	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Gastroenterologist	<input type="checkbox"/> Rheumatologist															
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<input type="checkbox"/> Gastroenterologist	<input type="checkbox"/> Rheumatologist																								
<p>Ankylosing Spondylitis:</p> <p>For Cimzia (certolizumab), Humira (adalimumab), or Simponi (golimumab) requests:</p> <p>Has the patient had inadequate response or inability to tolerate two NSAIDs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>For Cosentyx (secukinumab) or Enbrel (etanercept) requests:</p> <p>Does the patient have active disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Select if the patient has had inadequate response or inability to tolerate the following:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 25%;"><input type="checkbox"/> Cimzia (certolizumab)</td> <td style="width: 25%;"><input type="checkbox"/> Humira (adalimumab)</td> <td style="width: 25%;"><input type="checkbox"/> Simponi (golimumab)</td> <td style="width: 25%;"><input type="checkbox"/> Taltz (ixekizumab)</td> </tr> </table> <p>Is this request for continuation of therapy with the requested product? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>For Taltz (ixekizumab) requests:</p> <p>Does the patient have active disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Select if the patient has had inadequate response or inability to tolerate the following:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;"><input type="checkbox"/> Cimzia (certolizumab)</td> <td style="width: 33%;"><input type="checkbox"/> Humira (adalimumab)</td> <td style="width: 33%;"><input type="checkbox"/> Simponi (golimumab)</td> </tr> </table> <p>Is this request for continuation of therapy with the requested product? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>						<input type="checkbox"/> Cimzia (certolizumab)	<input type="checkbox"/> Humira (adalimumab)	<input type="checkbox"/> Simponi (golimumab)	<input type="checkbox"/> Taltz (ixekizumab)	<input type="checkbox"/> Cimzia (certolizumab)	<input type="checkbox"/> Humira (adalimumab)	<input type="checkbox"/> Simponi (golimumab)													
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Immune Modulating Therapy Prior Authorization Request Form (Page 2 of 6)

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Crohn's Disease:

For **Cimzia** (certolizumab), **Humira** (adalimumab), or **Stelara** (ustekinumab) requests:

Does the patient have moderate to severe Crohn's disease? Yes No

Select if the patient has had inadequate response or inability to tolerate one drug from any of the following groups:

- Aminosalicylates: mesalamine (Asacol, Canasa, Pentasa, Rowasa), sulfasalazine
- Antibiotics: levofloxacin, metronidazole
- Corticosteroids: budesonide (Entocort EC), hydrocortisone, methylprednisolone, prednisone
- Immunomodulators: 6-mercaptopurine, azathioprine, cyclosporine, methotrexate, tacrolimus (Prograf)

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? Yes No

Cryopyrin-Associated Periodic Syndromes (CAPS):

For **Arcalyst** (rilonacept) requests:

Does the patient have a diagnosis of cryopyrin-associated periodic syndromes (CAPS), including familial cold auto-inflammatory syndrome (FCAS) and/or Muckle-Wells syndrome (MWS)? Yes No

Was Arcalyst prescribed by or in consultation with an immunologist, allergist, dermatologist, rheumatologist, neurologist or other medical specialist? Yes No

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? Yes No

For **Kineret** (anakinra) requests:

Does the patient have a diagnosis of neonatal onset multisystem inflammatory disease (NOMID)? Yes No

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? Yes No

Deficiency of Interleukin-1 Receptor Antagonist (DIRA):

For **Arcalyst** (rilonacept) requests:

Is Arcalyst being used for the maintenance of remission of Deficiency of Interleukin-1 Receptor Antagonist (DIRA)? Yes No

Does the patient weigh at least 10kg? Yes No

Was Arcalyst prescribed by or in consultation with a rheumatologist or pediatric specialist? Yes No

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? Yes No

For **Kineret** (anakinra) requests:

Was Kineret prescribed by or in consultation with a rheumatologist or pediatric specialist? Yes No

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? Yes No

Giant Cell Arteritis:

For **Actemra SQ** (tocilizumab) requests:

Has the patient had inadequate response or inability to tolerate a glucocorticoid (i.e., prednisone)? Yes No

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? Yes No

Hidradenitis Suppurativa:

For **Humira** (adalimumab) requests:

Does the patient have moderate to severe hidradenitis suppurativa (i.e., Hurley stage II or III)? Yes No

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? Yes No

Non-radiographic Axial Spondyloarthritis (nr-axSpA):

For **Cimzia** (certolizumab) requests:

Does the patient have active non-radiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation? Yes No

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? Yes No

Continued on next page

Immune Modulating Therapy Prior Authorization Request Form (Page 3 of 6)

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Non-radiographic Axial Spondyloarthritis (nr-axSpA):

For **Cosentyx** (secukinumab) requests:

Does the patient have active non-radiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation? Yes No

Has the patient had an inadequate response or inability to tolerate Cimzia (certolizumab) AND Taltz (ixekizumab)? Yes No

Is this request for continuation of therapy with the requested product? Yes No

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? Yes No

For **Taltz** (ixekizumab) requests:

Does the patient have active non-radiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation? Yes No

Has the patient had an inadequate response or inability to tolerate Cimzia (certolizumab)? Yes No

Is this request for continuation of therapy with the requested product? Yes No

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? Yes No

Plaque Psoriasis:

For **Cimzia** (certolizumab), **Humira** (adalimumab), **Otezla** (apremilast), **Skyrizi** (risankizumab), **Stelara** (ustekinumab), or **Tremfya** (guselkumab) requests:

Does the patient have moderate to severe chronic plaque psoriasis? Yes No

Has the patient had inadequate response or inability to tolerate one of the following: Topical calcipotriene-containing products, topical anthralin, topical steroids, topical immune modulators (Elidel, Protopic), and/or topical retinoids? Yes No

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? Yes No

For **Cosentyx** (secukinumab) or **Enbrel** (etanercept) requests:

Does the patient have moderate to severe chronic plaque psoriasis? Yes No

Has the patient had inadequate response or inability to tolerate one of the following: Topical calcipotriene-containing products, topical anthralin, topical steroids, topical immune modulators (Elidel, Protopic), and/or topical retinoids? Yes No

Select if the patient has had inadequate response or inability to tolerate the following:

- | | | |
|---|---|--|
| <input type="checkbox"/> Cimzia (certolizumab) | <input type="checkbox"/> Humira (adalimumab) | <input type="checkbox"/> Skyrizi (risankizumab) |
| <input type="checkbox"/> Stelara (ustekinumab) | <input type="checkbox"/> Taltz (ixekizumab) | <input type="checkbox"/> Tremfya (guselkumab) |

Is this request for continuation of therapy with the requested product? Yes No

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? Yes No

For **Siliq** (brodalumab) requests:

Does the patient have moderate to severe chronic plaque psoriasis? Yes No

Has the patient had inadequate response or inability to tolerate one of the following: Topical calcipotriene-containing products, topical anthralin, topical steroids, topical immune modulators (Elidel, Protopic), and/or topical retinoids? Yes No

Select if the patient has had inadequate response or inability to tolerate the following:

- | | | |
|---|---|--|
| <input type="checkbox"/> Cimzia (certolizumab) | <input type="checkbox"/> Humira (adalimumab) | <input type="checkbox"/> Skyrizi (risankizumab) |
| <input type="checkbox"/> Stelara (ustekinumab) | <input type="checkbox"/> Taltz (ixekizumab) | <input type="checkbox"/> Tremfya (guselkumab) |

Is this request for continuation of therapy with the requested product? Yes No

Has the patient been evaluated for depression and suicidal ideations using the PHQ-9? Yes No

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? Yes No

Reauthorization for Siliq:

Has the patient had positive response to therapy with Siliq (brodalumab)? Yes No

Has the patient been evaluated for depression and suicidal ideations using the PHQ-9? Yes No

For **Taltz** (ixekizumab) requests:

Does the patient have moderate to severe chronic plaque psoriasis? Yes No

Has the patient had inadequate response or inability to tolerate one of the following: Topical calcipotriene-containing products, topical anthralin, topical steroids, topical immune modulators (Elidel, Protopic), and/or topical retinoids? Yes No

Select if the patient has had inadequate response or inability to tolerate the following:

- | | | |
|---|--|--|
| <input type="checkbox"/> Cimzia (certolizumab) | <input type="checkbox"/> Humira (adalimumab) | <input type="checkbox"/> Skyrizi (risankizumab) |
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Is this request for continuation of therapy with the requested product? Yes No

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? Yes No

Immune Modulating Therapy Prior Authorization Request Form (Page 4 of 6)

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Polyarticular Juvenile Idiopathic Arthritis (PJIA):

For **Actemra SQ** (tocilizumab), **Orencia SQ** (abatacept), or **Xeljanz** (tofacitinib) requests:

Does the patient have moderate to severe PJIA? Yes No

Has the patient had inadequate response or inability to tolerate **Humira** (adalimumab)? Yes No

Is this request for continuation of therapy with the requested product? Yes No

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? Yes No

For **Enbrel** (etanercept) requests:

Does the patient have moderate to severe PJIA? Yes No

Select if the patient has had inadequate response or inability to tolerate the following:

Actemra (tocilizumab)

Humira (adalimumab)

Orencia SQ (abatacept)

Xeljanz tablets and oral solution (tofacitinib)

Is this request for continuation of therapy with the requested product? Yes No

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? Yes No

For **Humira** (adalimumab) requests:

Does the patient have moderate to severe PJIA? Yes No

Has the patient had inadequate response or inability to tolerate one of the following disease-modifying anti-rheumatic drugs (DMARDs): Methotrexate, hydroxychloroquine, leflunomide, azathioprine, sulfasalazine? Yes No

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? Yes No

Psoriatic Arthritis:

For **Cimzia** (certolizumab), **Humira** (adalimumab), **Otezla** (apremilast), **Simponi** (golimumab), **Stelara** (ustekinumab) or **Tremfya** (guselkumab) requests:

Does the patient have moderate to severe psoriatic arthritis? Yes No

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? Yes No

For **Cosentyx** (secukinumab) or **Enbrel** (etanercept) requests:

Does the patient have moderate to severe psoriatic arthritis? Yes No

Select if the patient has had inadequate response or inability to tolerate the following:

Cimzia (certolizumab)

Humira (adalimumab)

Orencia SQ (abatacept)

Simponi (golimumab)

Stelara (ustekinumab)

Taltz (ixekizumab)

Tremfya (guselkumab)

Xeljanz/Xeljanz XR tablets/extended-release tablets (tofacitinib)

Is this request for continuation of therapy with the requested product? Yes No

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? Yes No

For **Orencia SQ** (abatacept), **Taltz** (ixekizumab), or **Xeljanz/Xeljanz XR** tablets/extended-release tablets (tofacitinib) requests:

Does the patient have moderate to severe psoriatic arthritis? Yes No

Select if the patient has had inadequate response or inability to tolerate the following:

Cimzia (certolizumab)

Humira (adalimumab)

Simponi (golimumab)

Stelara (ustekinumab)

Tremfya (guselkumab)

Is this request for continuation of therapy with the requested product? Yes No

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? Yes No

Recurrent Pericarditis:

For **Arcalyst** (riloncept) requests:

Is Arcalyst being used for the treatment of recurrent pericarditis and reduction in risk of recurrence? Yes No

Was Arcalyst prescribed by or in consultation with a cardiologist? Yes No

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? Yes No

Immune Modulating Therapy Prior Authorization Request Form (Page 5 of 6)

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Rheumatoid Arthritis:

For **Actemra SQ** (tocilizumab) or **Orencia SQ** (abatacept) requests:

Does the patient have moderate to severe rheumatoid arthritis? Yes No

Select if the patient has had inadequate response or inability to tolerate the following:

- Cimzia** (certolizumab) **Humira** (adalimumab) **Rinvoq** (upadacitinib)
 Simponi (golimumab) **Xeljanz/Xeljanz XR** (tofacitinib)

Is this request for continuation of therapy with the requested product? Yes No

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? Yes No

For **Cimzia** (certolizumab), **Humira** (adalimumab), **Rinvoq** (upadacitinib), **Simponi** (golimumab), or **Xeljanz/Xeljanz XR** (tofacitinib) requests:

Does the patient have moderate to severe rheumatoid arthritis? Yes No

Has the patient had inadequate response or inability to tolerate one of the following disease-modifying anti-rheumatic drugs (DMARDs): Methotrexate, hydroxychloroquine, leflunomide, azathioprine, sulfasalazine? Yes No

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? Yes No

For **Enbrel** (etanercept), **Kevzara** (sarilumab), **Kineret** (anakinra), or **Olumiant** (baricitinib) requests:

Does the patient have moderate to severe rheumatoid arthritis? Yes No

Select if the patient has had inadequate response or inability to tolerate the following:

- Actemra SQ** (tocilizumab) **Cimzia** (certolizumab) **Humira** (adalimumab) **Orencia SQ** (abatacept)
 Rinvoq (upadacitinib) **Simponi** (golimumab) **Xeljanz/Xeljanz XR** (tofacitinib)

Is this request for continuation of therapy with the requested product? Yes No

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? Yes No

Systemic Juvenile Idiopathic Arthritis (SJIA):

For **Actemra SQ** (tocilizumab) requests:

Does the patient have active systemic juvenile idiopathic arthritis (SJIA)? Yes No

Select if the patient has had inadequate response or inability to tolerate one of the following:

- DMARDs (e.g. leflunomide, methotrexate)
 Non-steroidal anti-inflammatory drug (NSAID) (e.g., ibuprofen)
 Systemic glucocorticoid (e.g., prednisone)

Systemic sclerosis-associated interstitial lung disease (SSc-ILD):

For **Actemra SQ** (tocilizumab) requests:

Was the diagnosis of SSc-ILD confirmed by a High Resolution CT scan or biopsy? Yes No

Select if the patient has had inadequate response or inability to tolerate the following:

- Azathioprine
 Cyclophosphamide
 Mycophenolate

Was Actemra prescribed by or in consultation with a pulmonologist? Yes No

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? Yes No

Ulcer of the mouth associated with Behcet's syndrome:

For **Otezla** (apremilast) requests:

Has the patient had inadequate response or inability to tolerate systemic corticosteroids, topical corticosteroids, or topical sucralfate? Yes No

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? Yes No

Immune Modulating Therapy Prior Authorization Request Form (Page 6 of 6)

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Ulcerative Colitis:

For **Humira** (adalimumab), **Simponi** (golimumab) or **Stelara** (ustekinumab) requests:

Does the patient have moderate to severe ulcerative colitis? Yes No

Has the patient had inadequate response or inability to tolerate one of the following medications: Corticosteroids, azathioprine, and/or 6-mercaptopurine? Yes No

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? Yes No

For **Xeljanz/Xeljanz XR** tablets/extended-release tablets (tofacitinib) requests:

Does the patient have moderate to severe ulcerative colitis? Yes No

Has the patient had inadequate response or inability to tolerate one of the following medications: Corticosteroids, azathioprine, 6-mercaptopurine? Yes No

Select if the patient has inadequate response or inability to tolerate the following:

Humira (adalimumab) **Simponi** (golimumab) **Stelara** (ustekinumab)

Is this request for continuation of therapy with the requested product? Yes No

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? Yes No

Uveitis:

For **Humira** (adalimumab) requests:

Does the patient have non-infectious intermediate, posterior, or panuveitis? Yes No

Has the patient had inadequate response or inability to tolerate ophthalmic and oral corticosteroids? Yes No

Will the patient be using the requested medication concurrently with any other biologic DMARDs (i.e., tumor necrosis factor antagonists)? Yes No

Reauthorization:

If this is a reauthorization request, answer the following:

Is there documentation of positive clinical response to therapy? Yes No

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.