Cytokine & CAM Antagonists

Please provide the information below, please print your answer, attach supporting documentation, sign, date, and return to our office as soon as possible to expedite this request. **Please FAX responses to: (800) 869-7791. Phone: (855) 322-4082, Options 0,1,2,3**

Apple Health Preferred Drug List: *https://www.hca.wa.gov/assets/billers-and-providers/apple-health-preferred-drug-list.xlsx*

Date of request:			
Patient	Date of birth	Molina ID	
Pharmacy name	Pharmacy NPI	Telephone number	Fax number
Prescriber	Prescriber NPI	Telephone number	Fax number
Medication and strength	Directions for use	Qty/Days supply	

1. Is client currently stable on therapy? ☐ Yes ☐ No
   If yes, is there documentation of positive clinical response? ☐ Yes ☐ No

2. What is patient's current weight? _____ kg Date taken: _____

3. Indicate patient's diagnosis:
   ☐ Ankylosing Spondylitis (AS) ☐ Crohn's Disease (CD) ☐ Hidradenitis Suppurativa (HS)
   ☐ Juvenile Idiopathic Arthritis (JIA) ☐ Plaque Psoriasis (Ps) ☐ Psoriatic Arthritis (PsA)
   ☐ Rheumatoid Arthritis (RA) ☐ Ulcerative Colitis (UC)
   ☐ Non-radiographic axial spondyloarthritis
   ☐ Non-infectious Uveitis (UV) classified as intermediate, posterior or panuveitis
   ☐ Other. Specify: _____

4. Has patient tried and failed, has an intolerance or contraindication to any of the following(check all that apply):
   ☐ Acetretin ☐ Corticosteroids ☐ Enbrel (etanercept)
   ☐ Humira (adalimumab) ☐ mesalamine/budesonide MMX ☐ NSAIDs
   ☐ Phototherapy ☐ systemic antibiotics ☐ topical therapies
   ☐ Non-biologic DMARD(s) (azathioprine, cyclosporine, hydroxychloroquine, leflunomide, 6-mercaptopurine, methotrexate, sulfasalazine)
   ☐ Other. Specify: _____

5. Will patient be taking any of the following in combination with this request (mark all that apply)?
   ☐ Biologic DMARD ☐ Phosphodiesterase (PDE 4) inhibitor
   ☐ Janus kinase inhibitor ☐ None

6. Does patient have a negative TB test within the last year? ☐ Yes ☐ No

7. Is this prescribed by or in consultation with any of the following (mark all that apply):

☐ Dermatologist ☐ Gastroenterologist ☐ Ophthalmologist ☐ Rheumatologist ☐ Other. Specify: _____		
CHART NOTES ARE REQUIRED WITH THIS REQUEST		
Prescriber signature	Prescriber specialty	Date