



MOLINA HEALTHCARE
Service Authorization (SA) Form
Cytokine and CAM Antagonists and
Related Agents

If the following information is not complete, correct, or legible, the SA process can be delayed.
 Please use one form per member.

MEMBER INFORMATION

Last name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

First name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Medicaid ID number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Date of birth:

				-					-				
--	--	--	--	---	--	--	--	--	---	--	--	--	--

Gender: Male Female

Weight in kilograms: _____

PRESCRIBER INFORMATION

Last name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

First name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

NPI number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Phone number:

				-					-				
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Fax number:

				-					-				
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DRUG INFORMATION

Does NOT require SA: Enbrel®, Humira®, or Inflectra®

Drug name/Form: _____

Strength: _____

Dosing frequency: _____

Length of therapy: _____

Quantity per day: _____

(Form continued on next page.)

Member's last name:

Member's first name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

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DIAGNOSIS AND MEDICAL INFORMATION

Does the member meet the following criteria?

1. Diagnosis (*check all that apply*):

- | | |
|---|--|
| <input type="checkbox"/> Rheumatoid Arthritis (RA) | <input type="checkbox"/> Adult Crohn's disease (CD) |
| <input type="checkbox"/> Pediatric Crohn's Disease | <input type="checkbox"/> Juvenile Idiopathic Arthritis (JIA) |
| <input type="checkbox"/> Psoriatic arthritis (PsA) | <input type="checkbox"/> Hidradenitis Suppurativa (HS) |
| <input type="checkbox"/> Ankylosing Spondylitis (AS) | <input type="checkbox"/> Ulcerative Colitis (UC) |
| <input type="checkbox"/> Uveitis (UV) | <input type="checkbox"/> Plaque Psoriasis (PsO) |
| <input type="checkbox"/> Polyarticular juvenile idiopathic arthritis (pJIA) | |
| <input type="checkbox"/> Disease is classified as moderate to severe | |
| <input type="checkbox"/> Diagnosis not listed above: _____ | |

2. Does the member have a therapeutic failure to oral methotrexate?

- Yes No N/A

3. Does the member have a therapeutic failure to one of the preferred agents?

- Yes No

a. Please provide details of failure below:

4. **Medical Necessity** (Provide clinical evidence that supports the use of the requested medication):

Prescriber signature (Required)

Date

By signature, the Physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; incomplete forms will delay the SA process.

Submission of documentation does NOT guarantee coverage by Molina Healthcare.

The completed form may be **faxed to 1-844-278-5731**, or you may call **(800) 424-4518. (TTY: 711)**