

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:

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First Name:

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

Medicaid ID Number:

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

Date of Birth:

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

Gender: Male Female

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name:

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First Name:

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

NPI Number:

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

Phone Number:

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

Fax Number:

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DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

Preferred drugs Enbrel®, Humira®, or Renflexis® do not require an SA. All Non-Preferred drugs listed below require a SA:

- | | | | | |
|-------------------------------------|------------------------------------|-----------------------------------|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Actemra® | <input type="checkbox"/> Arcalyst® | <input type="checkbox"/> Avsola™ | <input type="checkbox"/> Cimzia® | <input type="checkbox"/> Cosentyx® |
| <input type="checkbox"/> Dupixent® | <input type="checkbox"/> Enspryng™ | <input type="checkbox"/> Entyvio® | <input type="checkbox"/> Ilaris® | <input type="checkbox"/> Ilumya™ |
| <input type="checkbox"/> Inflectra® | <input type="checkbox"/> Kevzara® | <input type="checkbox"/> Kineret® | <input type="checkbox"/> Olumiant® | <input type="checkbox"/> Orencia® |
| <input type="checkbox"/> Otezla® | <input type="checkbox"/> Otrexup® | <input type="checkbox"/> Rasuvo® | <input type="checkbox"/> Remicade® | <input type="checkbox"/> Rinvoq™ |
| <input type="checkbox"/> Siliq® | <input type="checkbox"/> Simponi® | <input type="checkbox"/> Skyrizi® | <input type="checkbox"/> Stelara® | <input type="checkbox"/> Taltz® |
| <input type="checkbox"/> Tremfya™ | <input type="checkbox"/> Trexall® | <input type="checkbox"/> Xatmep® | <input type="checkbox"/> Xeljanz® | <input type="checkbox"/> Xeljanz® XR |

(Form continued on next page.)

Member's Last Name:

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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):

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

2. Therapeutic failure to oral methotrexate?

- Yes No N/A

3. 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 Complete Care.

The completed form may be **FAXED to 1-844-278-5731**, or you may call the number below.

CCC Plus: 1-800-424-4524 (TTY 711)

Medallion 4.0: 1-800-424-4518 (TTY 711)

www.MCCofVA.com