MOLINA COMPLETE CARE - CCC PLUS
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: ☐☐☐ – ☐☐☐ – ☐☐☐☐ **Fax Number:** ☐☐☐ – ☐☐☐ – ☐☐☐☐

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:

☐ Actemra®	☐ Arcalyst®	☐ Avsola™	☐ Cimzia®	☐ Cosentyx®
☐ Dupixent®	☐ Enspryng™	☐ Entyvio®	☐ Ilaris®	☐ Ilumya™
☐ Inflectra®	☐ Kevzara®	☐ Kineret®	☐ Olumiant®	☐ Orencia®
☐ Otezla®	☐ Otrexup®	☐ Rasuvo®	☐ Remicade®	☐ Rinvoq™
☐ Siliq®	☐ Simponi®	☐ Skyrizi®	☐ Stelara®	☐ Taltz®
☐ Tremfya™	☐ Trexall®	☐ Xatmep®	☐ Xeljanz®	☐ Xeljanz® XR

(Form continued on next page.)

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Member's Last Name: | | | | | | | | | | | |

Member's First Name: | | | | | | | | | | | |

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 the Department of Medical Assistance Services.

The completed form may be faxed to **1-800-922-3986,** phoned to **1-800-424-4524 (TTY 711)** or mailed to:

Magellan Rx Management Prior Authorization Program

c/o Molina Complete Care

11013 West Broad Street

Glen Allen, VA 23060

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