



**Request for Prior Authorization
BIOLOGICALS FOR INFLAMMATORY
BOWEL DISEASE**

**FAX Completed Form To
1 (877) 733-3195
Provider Help Desk
1 (844) 236-1464**

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID # _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _	Patient name	DOB
Patient address		
Provider NPI _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _	Pharmacy fax	NDC _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Prior authorization is required for biologicals used for inflammatory bowel disease. Request must adhere to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations. Payment for non-preferred biologicals for inflammatory bowel disease will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered under the following conditions:

1. Patient has a diagnosis of moderate to severe Crohn’s Disease; or
2. Patient has a diagnosis of moderate to severe Ulcerative Colitis; and
3. Medication will be administered in the patient’s home by patient or patient’s caregiver.

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Preferred

- | | |
|--|--|
| <input type="checkbox"/> Adalimumab-aacf | <input type="checkbox"/> Simlandi |
| <input type="checkbox"/> Adalimumab-adbm | <input type="checkbox"/> Simponi |
| <input type="checkbox"/> Adalimumab-fkjp | <input type="checkbox"/> Skyrizi Auto-Injector |
| <input type="checkbox"/> Amjevita 40mg/0.4mL | <input type="checkbox"/> Skyrizi Cartridge |
| <input type="checkbox"/> Amjevita 80mg/0.8mL | <input type="checkbox"/> Skyrizi Prefilled Syringe |
| <input type="checkbox"/> Humira | <input type="checkbox"/> Tremfya |
| | <input type="checkbox"/> Yusimry |

Non-Preferred

- | |
|---|
| <input type="checkbox"/> Cimzia Prefilled Syringe |
| <input type="checkbox"/> Entyvio SQ Pen Injector |
| <input type="checkbox"/> Omvoh Auto-Injector |
| <input type="checkbox"/> Stelara |
| <input type="checkbox"/> Zymfentra |
| <input type="checkbox"/> Other Humira Biosimilar: _____ |

Strength	Dosage Instructions	Quantity	Days Supply
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Diagnosis:

- | |
|---|
| <input type="checkbox"/> Moderate to Severe Crohn’s Disease |
| <input type="checkbox"/> Moderate to Severe Ulcerative Colitis |

Will medication be administered in the patient’s home by patient or patient’s caregiver? **Yes** **No**

Possible drug interactions/conflicting drug therapies/other medical conditions to consider: _____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission
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IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member’s Medicaid eligibility card and, if necessary by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.