MOLINA HEALTHCARE

Iowa Department of Human Services

Iowa Health Link IOWA HHS Hawki Iowa HHS

Request for Prior Authorization
BIOLOGICALS FOR ARTHRITIS

(PLEASE PRINT – ACCURACY IS IMPORTANT)

FAX Completed Form To
1 (877) 733-3195

Provider Help Desk
1 (844) 236-1464

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 arthritis. Request must adhere to all FDA approved labeling, including age, indication, dosing, and contraindications. Payment for non-preferred biologicals for arthritis will be considered only for cases in which there is documentation of previous trials and therapy failures with two preferred biological agents. Payment will be considered under the following conditions: 1) Patient has been screened for latent TB infection, patients with latent TB will only be considered after one month of TB treatment and patients with active TB will only be considered upon completion of TB treatment; and 2) Patient has been screened for hepatitis B and C. Patients with evidence of active hepatitis B infection (hepatitis surface antigen positive > 6 months) must have documentation they are receiving or have received effective antiviral treatment.

In addition to the above:

Requests for TNF Inhibitors: 1) Patient has not been treated for solid malignancies, nonmelanoma skin cancer, or lymphoproliferative malignancy within the last 5 years of starting or resuming treatment with a biological agent; and 2) Patient does not have a diagnosis of congestive heart failure (CHF) that is New York Heart Association (NYHA) class III or IV and with an ejection fraction of 50% or less.

Requests for Interleukins: Medication will not be given concurrently with live vaccines.

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

Preferred

- ☐ Enbrel
- ☐ Humira
- ☐ Kineret
- ☐ Taltz (after step through one preferred TNF)

Non-Preferred

- ☐ Actemra
- ☐ Cimzia (prefilled syringe)
- ☐ Cosentyx
- ☐ Ilaris
- ☐ Kevzara
- ☐ Orencia
- ☐ Simponi
- ☐ Skyrizi
- ☐ Stelara

Strength	Dosage Instructions	Quantity	Days Supply
_____	_____	_____	_____

Screening for Hepatitis B: Date:_____ Active Disease: ☐ Yes ☐ No

Screening for Hepatitis C: Date:_____ Active Disease: ☐ Yes ☐ No

Screening for Latent TB infection: Date:_____ Results: _____

Requests for TNF Inhibitors:

Has patient received treatment for solid malignancies, nonmelanoma skin cancer, or lymphoproliferative malignancy within last 5 years of starting or resuming treatment with a biologic agent? ☐ Yes ☐ No

Request for Prior Authorization
BIOLOGICALS FOR ARTHRITIS
(PLEASE PRINT – ACCURACY IS IMPORTANT)

Does patient have a diagnosis of NYHA class III or IV CHF diagnosis with ejection fraction of 50% or less? ☐ Yes ☐ No
Requests for Interleukins:

Will medication be given concurrently with live vaccines? ☐ Yes ☐ No

☐ **Rheumatoid arthritis (RA); with**
Documentation of a trial and inadequate response, at a maximally tolerated dose, with methotrexate (hydroxychloroquine, sulfasalazine, or leflunomide may be used if methotrexate is contraindicated).

Drug Name & Dose: _____Trial dates: _____
Failure reason: _____

☐ **Psoriatic arthritis, moderate to severe; with**
Documentation of a trial and inadequate response, at a maximally tolerated dose, with methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated).

Drug Name &Dose: _____Trial dates: _____
Failure reason: _____

☐ **Juvenile idiopathic arthritis, moderate to severe; with**

Documentation of a trial and inadequate response to intraarticular glucocorticoid injections and methotrexate at a maximally tolerated dose (leflunomide or sulfasalazine may be used if methotrexate is contraindicated).

Intraarticular Glucocorticoid Injections: Drug Name & Dose: _____Trial dates: _____

Failure reason: _____

Plus methotrexate or preferred oral DMARD trial: Drug Name & Dose:_____
Trial dates:_____ Failure reason: _____

Reason for use of Non-Preferred drug requiring prior approval:_____
_____

Other medical conditions to consider: _____
Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

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 Human Services, that the member continues to be eligible for Medicaid.*