MOLINA HEALTHCARE

Iowa Health Link Hawki

Request for Prior Authorization

BIOLOGICALS FOR ARTHRITIS

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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 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 arthritis will be considered only for cases in which there is documentation of previous trials and therapy failures with two preferred biological agents.
The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Preferred

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

Non-Preferred

- ☐ Actemra
- ☐ Cimzia (prefilled syringe)
- ☐ Cosentyx
- ☐ Ilaris
- ☐ Kevzara
- ☐ Orencia Prefilled Syringe
- ☐ Skyrizi
- ☐ Stelara
- ☐ Humira Biosimilar: Drug Name_____

Strength	Dosage Instructions	Quantity	Days Supply
_____	_____	_____	_____

☐ **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: _____

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☐ **Juvenile idiopathic arthritis with oligoarthritis; 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: _____

☐ **Polyarticular juvenile idiopathic arthritis (pJIA), 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: _____

☐ **Systemic juvenile idiopathic arthritis (sJIA)**

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