# Nevada Medicaid

Submit fax request to: 855-455-3303

Please note: All information below is required to process this request.

## Immunomodulator Drugs Prior Authorization Request Form

**DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED.**

| Member Information (required) | | | Provider Information (required) | | |
|---|---|---|---|---|---|
| Member Name: | | | Provider Name: | | |
| Insurance ID#: | | | NPI#: | Specialty: | |
| Date of Birth: | | | Office Phone: | | |
| Street Address: | | | Office Fax: | | |
| City: | State: | Zip: | Office Street Address: | | |
| Phone: | | | City: | State: | Zip: |

## Medication Information (required)

| Medication Name: | Strength: | Dosage Form: |
|---|---|---|
| ❑ Check if request is for **continuation of therapy** | Directions for Use: | |

## Clinical Information (required)

**Clinical information required for all indications:**

- ☐ The recipient has had a negative tuberculin test
- ☐ The recipient does not have an active infection or a history of recurring infections
- ☐ Only one biologic medication is being used

**Rheumatoid Arthritis:**

- ☐ The recipient has a diagnosis of moderately to severely active RA
- ☐ The recipient is 18 years of age or older
- ☐ The recipient has had a rheumatology consultation, including the date of the visit: _____

Choose one of the following:

- ☐ The recipient has had RA for < six months (early RA) and has high disease activity; and an inadequate or adverse reaction to a disease modifying antirheumatic drug (DMARD) (methotrexate, hydroxychloroquine, leflunomide, minocycline and sulfasalazine)
- ☐ The recipient has had RA for > six months (intermediate or long-term disease duration) and has moderate disease activity and has an inadequate response to a DMARD (methotrexate, hydroxychloroquine, leflunomide, minocycline or sulfasalazine)
- ☐ The recipient has had RA for > six months (intermediate or long-term disease duration) and has high disease activity

**Psoriatic Arthritis**:

- ☐ The recipient has a diagnosis of moderate or severe psoriatic arthritis
- ☐ The recipient is 18 years of age or older
- ☐ The recipient has had a rheumatology consultation including the date of the visit or a dermatology consultation including the date of the visit: _____
- ☐ The recipient had an inadequate response or a contraindication to treatment with any one nonsteroidal anti-inflammatory (NSAID) or to any one of the following DMARDs: methotrexate, leflunomide, cyclosporine or sulfasalazine

**Ankylosing Spondylitis**.

- ☐ The recipient has a diagnosis of ankylosing spondylitis
- ☐ The recipient is 18 years of age or older
- ☐ The recipient has had an inadequate response to NSAIDs
- ☐ The recipient has had an inadequate response to any one of the DMARDs (methotrexate, hydroxychloroquine, sulfasalazine, leflunomide, minocycline)

## Clinical Information Cont. (required)

**Juvenile Rheumatoid Arthritis/Juvenile Idiopathic Arthritis**:

□ The recipient has a diagnosis of moderately or severely active juvenile RA or juvenile idiopathic arthritis

□ The recipient is at an appropriate age, based on the requested agent:

- Abatacept: Six years of age or older
- Adalimumab, canakinumab, etanercept, tocilizumab: Two years of age or older

□ The recipient has at least five swollen joints

□ The recipient has three or more joints with limitation of motion and pain, tenderness, or both

□ The recipient has had an inadequate response to one DMARD

**Plaque Psoriasis:**

□ The recipient has a diagnosis of chronic, moderate to severe plaque psoriasis

□ The recipient is 18 years of age or older

□ The agent is prescribed by a dermatologist

□ The recipient has failed to adequately respond to a topical agent

□ The recipient has failed to adequately respond to at least one oral treatment

**Crohn's Disease:**

□ The recipient has a diagnosis of moderate to severe Crohn's Disease

□ The recipient is at an appropriate age, based on the requested agent:

- Humira: Five years of age or older
- Infliximab: Six years of age or older
- All others: 18 years of age or older

□ The recipient has failed to adequately respond to one or more conventional therapies (e.g., sulfasalazine, mesalamine, antibiotics, corticosteroids, azathioprine, 6-mercaptopurine, leflunomide); or □ The recipient has fistulizing Crohn's Disease

**Ulcerative Colitis (UC):**

□ The recipient has a diagnosis of moderate to severe ulcerative colitis

□ The recipient is at an appropriate age, based on the requested agent:

- Humira: Five years of age or older
- Infliximab: Six years of age or older
- All others: 18 years of age or older

□ The recipient has failed to adequately respond to one or more of the following standard therapies: Corticosteroid, 5-Aminosalicylic acid agents, immunosuppressants and/or Thiopurines

**Cryopyrin-Associated Periodic Syndromes (CAPS): Familial Cold Autoinflammatory Syndromes (FCAS) or Muckle-Wells Syndrome (MWS)**

□ The recipient has a diagnosis of FCAS or MWS

□ The recipient is at an appropriate age, based on the requested agent:

- Canakinumab: Four years of age or older
- Rilonacept: 12 years of age or older

**Cryopyrin-Associated Periodic Syndromes (CAPS): Neonatal-Onset Multisystem Inflammatory Disease (NOMID):**

□ The recipient has a diagnosis of NOMID

**Drug Specific Criteria:**

Zeposia® (ozanimod)

□ The recipient has a diagnosis of moderately to severely active ulcerative colitis

□ Prescribed by or in consultation with a gastroenterologist

□ The recipient has failed to adequately respond after a 90-day trial to one or more conventional therapies (e.g., sulfasalazine, aminosalicylates, 6-mercaptopurine, corticosteroids, azathioprine)

□ The recipient has tried and failed two preferred immunomodulator therapies indicated for moderately to severely active ulcerative colitis

**Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?**

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.