Prior Authorization Request
Nevada Medicaid – OptumRx

Targeted Immunomodulators

Submit fax request to: 855-455-3303
Purpose: For a prescribing physician to request prior authorization for a targeted immunomodulator.*
Questions: If you have questions, call the OptumRx Call Center for Nevada Medicaid at 855-455-3311.

DATE OF REQUEST:		
RECIPIENT INFORMATION		
Last Name, First Name, Middle Initial:		Date of Birth:
Recipient ID:	Gender: ☐ Male ☐ Female	Phone:
PRESCRIBING PROVIDER INFORMATION		
Name:	NPI:	Specialty:
Phone:	Fax (required):	
Person to contact regarding this request:		
DIAGNOSIS AND REQUESTED DRUG		
Name:	Strength:	
Dosage:	Duration:	

Please document the recipient's diagnosis:

☐ Ankylosing Spondylitis ☐ Juvenile Rheumatoid Arthritis ☐ Plaque Psoriasis ☐ Crohn's Disease
☐ Psoriatic Arthritis ☐ Juvenile Idiopathic Arthritis ☐ Rheumatoid Arthritis ☐ Other:_____

CLINICAL INFORMATION

Check the applicable boxes to indicate each item as true for the recipient:

☐ The recipient has had a rheumatology consult. Date:_____ Duration of disease:_____ **(if applicable)**
☐ The recipient has had a dermatology consult. Date:_____ Duration of disease:_____ **(if applicable)**
☐ The recipient has fistulizing Crohn's disease **(Crohn's disease only)**.
☐ The recipient has mild disease activity.
☐ The recipient has moderate disease activity.
☐ The recipient has high/severe disease activity.
☐ The recipient has at least 5 swollen joints **(Juvenile Arthritis only)**.
☐ The recipient has at least 3 joints with limitations in motion and pain or tenderness **(Juvenile Arthritis only)**.
☐ The recipient does not have moderate to severe heart failure (NYHA class III or IV).
☐ The recipient does not have a history of treated lymphoproliferative disease in the previous 5 years.
☐ The recipient does not have acute or chronic liver disease classified as Child-Pugh class B or C.
☐ The recipient does not have multiple sclerosis or another demyelinating disorder.
☐ The recipient does not have an active infection or history of recurring infections.
☐ The recipient has had a negative tuberculin test prior to initiating requested treatment.
☐ The recipient has had a positive tuberculin test prior to initiating requested treatment.
☐ Treatment with isoniazid was started ≥1 month prior to initiating requested treatment **(only if test was positive)**.

List the medications that were tried and failed for the given diagnosis:

Drug Name	**Reason for Failure**	**Date(s)**
_____	_____	_____
_____	_____	_____

Additional clinical information (if applicable):

PROVIDER CERTIFICATION – *Prescriber's signature and date required.*

I hereby certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by Nevada Medicaid.

Prescriber's Signature: _____ Date: _____

*Authorization will not be given for the use of more than one biologic at a time (combination therapy).