AmeriHealth Caritas Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization
Biologicals for Arthritis

Form applies to IA Health Link and ***hawk-i*** plans.

Please print – accuracy is important.

Fax completed form to 1-855-825-2714. Provider Help Desk: 1-855-328-1612.

AmeriHealth Caritas Iowa member ID #:	Patient name:	
Patient address:		DOB:
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. Patients initiating therapy with a biological agent must 1) be screened for hepatitis B and C, patients with active hepatitis B will not be considered for coverage; 2) have 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; 3) not have a diagnosis of congestive heart failure (CHF) that is New York Heart Association (NYHA) class lll or IV and with an ejection fraction of 50% or less; and 4) be 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. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated. 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.

Please note: AmeriHealth Caritas Iowa uses Iowa Medicaid Enterprise criteria. For complete criteria, please consult www.iowamedicaidpdl.com/pa_criteria.

Preferred: ☐ Enbrel ☐ Humira

Non-Preferred: ☐ Actemra ☐ Cimzia (prefilled syringe) ☐ Inflectra ☐ Kineret ☐ Orencia ☐ Remicade ☐ Simponi ☐ 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:

Has patient received treatment for solid malignancies, nonmelanoma skin cancer, or lymphoproliferative malignancy within last five years of starting or resuming treatment with a biologic agent?

☐ Yes ☐ No

Does patient have a diagnosis of NYHA class lll or lV CHF diagnosis with ejection fraction of 50 percent or less:

☐ Yes ☐ No

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☐ **Rheumatoid arthritis (RA)** (Humira, Enbrel, Actemra, Cimzia, Kineret, Orencia, Remicade, Simponi) — Payment will be considered upon a trial and inadequate response to two preferred disease modifying antirheumatic drugs (DMARD) used concurrently. The combination must include methotrexate plus another preferred oral DMARD (hydroxychoroquine, sulfasalazine, leflunomide, or minocycline). Upon an unsuccessful methotrexate trial in patients with established RA, the combination trial with a second DMARD may be overridden if there is evidence of severe disease documented by radiographic erosions.

Methotrexate trial

Dose: Trial dates:

Failure reason:

Plus preferred oral DMARD trial

Drug name/dose: Trial dates:

Failure reason:

Radiographic evidence indicating erosions: ☐ Yes ☐ No

☐ **Psoriatic arthritis, moderate to severe** (Cimzia, Enbrel, Humira, Remicade, Simponi, Stelara) — Payment will be considered upon a trial and inadequate response to the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated).

Methotrexate or preferred oral DMARD trial

Drug name/dose: Trial dates:

Failure reason:

Methotrexate contraindication, if applicable:

☐ **Juvenile idiopathic arthritis, moderate to severe** (Enbrel, Humira, Actemra, Orencia) — Payment will be considered upon a trial and inadequate response to intraarticular glucocorticoid injections and the preferred oral DMARD, methotrexate (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:

Methotrexate contraindication, if applicable:

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Reason for use of non-preferred drug requiring prior approval:

Other medical conditions to consider:

Attach lab results and other documentation as necessary.

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further attest that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.	
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.

Check www.amerihealthcaritasia.com/Provider to confirm your version of this form.