AmeriHealth Caritas Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization
Biologicals for Hidradenitis Suppurativa

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 FDA approved for the treatment of Hidradenitis Suppurativa (HS). 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; and 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; and 3) Not have a diagnosis of congestive heart failure (CHF) that is New York Heart Association (NYHA) class lll or lV 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.

Payment will be considered under the following conditions: 1) Patient has a diagnosis of moderate to severe HS with Hurley Stage ll or lll disease; and 2) Patient is 18 years of age or older; and 3) Patient has at least three (3) abscesses or inflammatory nodules; and 4) Patient has documentation of adequate trials and therapy failures with the following: a) Daily treatment with topical clindamycin; b) Oral clindamycin plus rifampin; c) Maintenance therapy with tetracyclines (doxycycline or minocycline). If criteria for coverage are met, initial requests will be given for 3 months. Additional authorizations will be considered upon documentation of clinical response to therapy. Clinical response is defined as at least a 50% reduction in total abscess and inflammatory nodule count with no increase in abscess count and no increase in draining fistula count from initiation of therapy. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

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

Preferred: ☐ Humira

Strength: Quantity: Days Supply:

Dosage Instructions:

Screening for Hepatits B: Date: Active Disease: ☐ Yes ☐ No

Screening for Hepatits 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 5 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% or less: ☐ Yes ☐ No

Diagnosis:

☐ Hidradenitis Suppurativa: Hurley Stage: ☐ I ☐ II ☐ III

☐ Other:

Does patient have at least three (3) absesses or inflammatory nodules?

☐ Yes: Abscess/Nodule count: ☐ No Date obtained:

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Topical Clindamycin trial

Name/Dose: Trial dates:

Reason for failure:

Oral Clindamycin Plus Rifampin trial

Clindamycin

Dose: Trial dates::

Reason for failure:

Rifampin

Dose: Trial dates::

Reason for failure:

Maintenance Tetracycline trial (doxycycline or minocycline)

Name/Dose: Trial dates::

Reason for failure:

Renewals:

Document response to therapy:

Abscess/Nodule count: ☐ Increase ☐ Decrease (provide count): Date obtained:

Has patient had an increase in draining fistula count since initiation of therapy? ☐ Yes ☐ No

Other medical conditions to consider:

Possible drug interactions/conflicting drug therapies:

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 acknowledge 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.