UnitedHealthcare Community Plan

Cytokine and CAM Antagonists - Pennsylvania
Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Member Information			Prescriber Information		
Member Name:			Provider Name:		
Member ID:			NPI #:	Specialty:	
Date Of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	ZIP Code:	Office Street Address:		
Phone:	Allergies:		City:	State:	ZIP Code:

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____
Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____
Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Medication Information

Medication:	**Strength:**
Directions for use:	**Quantity:**

Medication Administered: ☐ Self-Administered ☐ Physician's Office ☐ Other: _____

Clinical Information

What is the patient's diagnosis for the medication being requested? _____
_____
ICD-10 Code(s): _____

Are there any supporting laboratory or test results related to the patient's diagnosis*? (Please specify or provide documentation)*

Previous Medication Trials / Contraindications

Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

What medication(s) does the patient have a history of failure to? *(Please specify ALL medication(s)/strengths tried, directions, length of trial, and reason for discontinuation of each medication)*

What medication(s) does the patient have a contraindication or intolerance to? *(Please specify ALL medication(s) with the associated contraindication to or specific issues resulting in intolerance to each medication)*

Additional information that may be important for this review

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Clinical and Drug Specific Information

ALL REQUESTS

□ Yes □ No	**Does the patient have one of the following diagnoses?** *(If yes, check which applies)* □ Active psoriatic arthritis □ Adult-onset Still's disease □ Ankylosing spondylitis or other axial spondyloarthritis □ Behçet's syndrome □ Crohn's disease □ Familial Mediterranean fever □ Giant cell arteritis □ Juvenile idiopathic arthritis □ Moderate-to-severe chronic atopic dermatitis □ Moderate-to-severe chronic psoriasis □ Moderate-to-severe hidradenitis suppurativa □ Moderately-to-severely active rheumatoid arthritis □ Non-infectious uveitis □ Sarcoidosis □ Ulcerative colitis
□ Yes □ No	**Is the requested medication prescribed by, or in consultation with, an appropriate specialist (e.g., gastroenterologist, dermatologist, rheumatologist, ophthalmologist, immunologist, genetic specialist, pulmonologist, oncologist, etc.)?**
□ Yes □ No	**Is the patient currently using a different Cytokine and Cell-adhesion molecule (CAM) Antagonist?**
□ Yes □ No □ Not applicable	**If yes to the above question, does the patient have any of the following?** *(If yes, check which applies)* □ Will discontinue use of that Cytokine and CAM Antagonist prior to starting the requested Cytokine and CAM Antagonist □ Has a medical reason for concomitant use of both Cytokine and CAM Antagonists that is supported by peer-reviewed literature or national treatment guidelines □ Is dependent on glucocorticoids in addition to a Cytokine and CAM Antagonist to prevent life-threatening complications □ Has 2 or more autoimmune or autoinflammatory conditions for which a single Cytokine and CAM Antagonist is not sufficient
□ Yes □ No	**Does the patient have a contraindication to the prescribed Cytokine and CAM Antagonist?**
□ Yes □ No	**Was the patient evaluated for active or latent tuberculosis infection documented by results of a tuberculin skin test (purified protein derivative) or blood test (interferon-gamma release assay)?**
□ Yes □ No	**Was the patient evaluated for hepatitis B virus infection documented by results of anti-HBs, HBsAg, and anti-HBc?**
□ Yes □ No □ Not applicable	**For a Cytokine and CAM Antagonist associated with behavioral and/or mood changes as stated in the FDA-approved package labeling (e.g., Otezla, Siliq), was the patient evaluated for a history of prior suicide attempt, bipolar disorder, or major depressive disorder?**
□ Yes □ No	**Does the patient have a history of therapeutic failure of or a contraindication, or an intolerance to the preferred Cytokine and CAM Antagonists approved or medically accepted for the patient's diagnosis?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)*
□ Yes □ No	**Does the patient have a current history (within the past 90 days) of being prescribed the same non-preferred Cytokine and CAM Antagonist?**

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ACTIVE PSORIATIC ARTHRITIS	
□ Yes □ No	**Does the patient have active psoriatic arthritis [defined as disease causing symptoms at an unacceptable bothersome level as reported by the patient and judged by the examining clinician to be due to PsA (psoriatic arthritis) based on 1 or more of the following: swollen joints, tender joints, dactylitis, enthesitis, axial disease, active skin and/or nail involvement, and extraarticular inflammatory manifestations such as uveitis or IBD (inflammatory bowel disease)]?**
□ Yes □ No	**Does the patient have axial disease and/or enthesitis?**
□ Yes □ No	**Does the patient have peripheral disease?**
□ Yes □ No	**Does the patient have a history of therapeutic failure of an 8-week trial of a conventional non-biologic DMARD?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)*
□ Yes □ No	**Does the patient have a contraindication or intolerance to conventional non-biologic DMARDs?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)*
□ Yes □ No	**Does the patient have severe disease as determined by the prescriber [examples include the presence of at least 1 of the following: a poor prognostic factor (erosive disease, elevated levels of inflammation markers such as C-reactive protein or erythrocyte sedimentation rate attributable to PsA), long-term damage that interferes with function (e.g., joint deformities, vision loss), highly active disease that causes major impairment in quality of life (i.e., active psoriatic inflammatory disease at many sites or function-limiting inflammatory disease at a few sites), and rapidly progressive disease]?**
□ Yes □ No	**Does the patient have concomitant moderate-to-severe nail disease?**
ADULT-ONSET STILL'S DISEASE	
□ Yes □ No	**Does the patient have predominantly systemic disease?**
□ Yes □ No	**Does the patient have a history of therapeutic failure of or a contraindication or an intolerance to systemic glucocorticoids?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)*
□ Yes □ No	**Does the patient have glucocorticoid-dependent Still's disease?**
□ Yes □ No	**Will the patient be using the requested medication with the intent of discontinuing or decreasing the dose of the systemic glucocorticoid?**
□ Yes □ No	**Does the patient have predominantly joint disease?**
□ Yes □ No	**Does the patient have a history of therapeutic failure of a conventional non-biologic DMARD?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)*
□ Yes □ No	**Does the patient have a contraindication or an intolerance to conventional non-biologic DMARDs?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)*
ANKYLOSING SPONDYLITIS OR OTHER AXIAL SPONDYLOARTHRITIS	
□ Yes □ No	**Does the patient have a history of therapeutic failure of a 2-week trial of continuous treatment with 2 different oral NSAIDs (i.e., an oral NSAID taken daily for 2 weeks and a different oral NSAID taken daily for 2 weeks)?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)*
□ Yes □ No	**Does the patient have a contraindication or an intolerance to oral NSAIDs?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)*
BEHÇET'S SYNDROME	
□ Yes □ No	**Does the patient have a diagnosis of Behçet's syndrome according to current consensus guidelines (e.g., EULAR, International Study Group for Behçet's Disease)?**
□ Yes □ No	**Does the patient have recurrent oral ulcers associated with Behçet's syndrome?**
□ Yes □ No	**Does the patient have a history of therapeutic failure of or a contraindication, or an intolerance to a topical corticosteroid (e.g., triamcinolone dental paste)?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)*
□ Yes □ No	**Does the patient have any of the following?** *(If yes, check which applies and complete "Previous Medication Trials/Contraindications" section on first page)* □ History of therapeutic failure of an adequate trial of colchicine at maximally tolerated doses □ A contraindication or an intolerance to colchicine

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CROHN'S DISEASE	
□ Yes □ No	**Does the patient have a diagnosis of moderate-to-severe Crohn's disease?**
□ Yes □ No	**Has the patient failed to achieve remission with or has a contraindication or intolerance to an induction course of corticosteroids?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)*
□ Yes □ No	**Has the patient failed to maintain remission with an immunomodulator in accordance with current consensus guidelines (e.g., American College of Gastroenterology [ACG], American Gastroenterological Association [AGA], Canadian Association of Gastroenterology [CAG], European Crohn's and Colitis Organization [ECCO])?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)*
□ Yes □ No	**Does the patient have a contraindication or an intolerance to immunomodulators in accordance with current consensus guidelines (e.g., American College of Gastroenterology [ACG], American Gastroenterological Association [AGA], Canadian Association of Gastroenterology [CAG], European Crohn's and Colitis Organization [ECCO])?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)*
□ Yes □ No	**Does the patient have a diagnosis of Crohn's disease that is associated with one or more high-risk or poor prognostic features (examples include: initial diagnosis or clinical evidence supports the onset of symptoms at <30 years of age, extensive anatomic involvement, presence of fistula, perianal and/or severe rectal disease, large or deep mucosal lesions on endoscopy or imaging, prior surgical resection, stricturing and/or penetrating behavior, need for steroid therapy at initial diagnosis, extra-intestinal manifestations, laboratory markers such as low hemoglobin, low albumin, high C-reactive protein, high fecal calprotectin levels, severe growth delay)?**
□ Yes □ No	**Has the patient achieved remission with the requested Cytokine and CAM antagonist?**
□ Yes □ No	**Will the patient be using the requested medication as maintenance therapy to maintain remission?**
FAMILIAL MEDITERRANEAN FEVER	
□ Yes □ No	**Does the patient have a history of therapeutic failure of at least a 3-month trial of colchicine at maximally tolerated doses?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)*
□ Yes □ No	**Does the patient have a contraindication or an intolerance to colchicine?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)*
GIANT CELL ARTERITIS	
□ Yes □ No	**Does the patient have a history of therapeutic failure of or a contraindication, or an intolerance to systemic glucocorticoids?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)*
□ Yes □ No	**Is the patient at high-risk for glucocorticoid-related complications?**
□ Yes □ No	**Does the patient have glucocorticoid-dependent disease?**
□ Yes □ No	**Will the patient be using the requested Cytokine and CAM Antagonist with the intent of discontinuing or decreasing the dose of the systemic glucocorticoid?**
JUVENILE IDIOPATHIC ARTHRITIS – continued on next page	
□ Yes □ No	**Does the patient have a history of therapeutic failure of a 3-month trial of a conventional non-biologic DMARD?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)*
□ Yes □ No	**Does the patient have a contraindication or an intolerance to non-biologic DMARDs?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)*
□ Yes □ No	**Does the patient have systemic juvenile idiopathic arthritis with active systemic features (examples include: fever, evanescent rash, lymphadenopathy, hepatomegaly, splenomegaly, and serositis)?**
□ Yes □ No	**Does the patient have one or more risk factors for disease severity (examples include: positive anti-cyclic citrullinated peptide antibodies, positive rheumatoid factor, presence of joint damage)?**

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	JUVENILE IDIOPATHIC ARTHRITIS – continued from previous page
□ **Yes** □ **No**	**Does the patient have any of the following?** *(If yes, check which applies)* □ High disease activity □ Involvement of high-risk joints (e.g., cervical spine, hip, wrist) □ Is at high risk of disabling joint damage as judged by the prescriber
□ **Yes** □ **No**	**Does the patient have active sacroiliitis and/or enthesitis?**
□ **Yes** □ **No**	**Does the patient have a history of therapeutic failure of a 2-week trial of an oral non-steroidal anti-inflammatory drug (NSAID)?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)*
□ **Yes** □ **No**	**Does the patient have a contraindication or an intolerance to oral NSAIDs?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)*
	MODERATE-TO-SEVERE CHRONIC ATOPIC DERMATITIS
□ **Yes** □ **No**	**Does the patient have a history of therapeutic failure to any of the following?** *(If yes, check which applies and complete "Previous Medication Trials/Contraindications" section on first page)* □ Low-potency topical corticosteroid (for treatment of the face, skin folds, or other critical areas) OR medium-potency or higher topical corticosteroid (for treatment of other areas) □ Phototherapy in accordance with current consensus guidelines □ Systemic immunosuppressives in accordance with current consensus guidelines (e.g., cyclosporine, azathioprine, methotrexate, mycophenolate mofetil) □ Topical calcineurin inhibitor
□ **Yes** □ **No**	**Does the patient have a history of contraindication or intolerance to any of the following?** *(If yes, check which applies and complete "Previous Medication Trials/Contraindications" section on first page)* □ Low-potency topical corticosteroid (for treatment of the face, skin folds, or other critical areas) OR medium-potency or higher topical corticosteroid (for treatment of other areas) □ Phototherapy in accordance with current consensus guidelines □ Systemic immunosuppressives in accordance with current consensus guidelines (e.g., cyclosporine, azathioprine, methotrexate, mycophenolate mofetil) □ Topical calcineurin inhibitor
	MODERATE-TO-SEVERE CHRONIC PSORIASIS
□ **Yes** □ **No**	**Does the patient have psoriasis associated with any of the following?** *(If yes, check which applies)* □ A body surface area (BSA) of 3 percent or more that is affected □ A BSA of less than 3 percent that is affected with involvement of critical areas (including, but not restricted to, hands, feet, scalp, face, genitals, nails, and intertriginous areas) □ Significant disability or impairment of physical or mental functioning
□ **Yes** □ **No**	**Does the patient have a history of therapeutic failure of topical corticosteroids OR other topical pharmacologic therapy (e.g., anthralin, calcineurin inhibitors, tar, tazarotene, vitamin D analogs)?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)*
□ **Yes** □ **No**	**Does the patient have a contraindication or an intolerance to topical corticosteroids AND other topical pharmacologic therapy?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)*
□ **Yes** □ **No**	**Does the patient have moderate to severe nail disease?**
□ **Yes** □ **No**	**Does the patient have a history of therapeutic failure of or a contraindication or an intolerance to any of the following?** *(If yes, check which applies and complete "Previous Medication Trials/Contraindications" section on first page)* □ 3-month trial of oral systemic therapy (e.g., methotrexate, cyclosporine, acitretin) □ Ultraviolet light therapy

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MODERATE-TO-SEVERE HIDRADENITIS SUPPURATIVA	
□ **Yes** □ **No**	**Does the patient have Hurley stage II or stage III disease?** *(If yes, check which applies)* □ Hurley stage II □ Hurley stage III
□ **Yes** □ **No**	**Does the patient have a history of therapeutic failure of or a contraindication, or an intolerance to any of the following?** *(If yes, check which applies and complete "Previous Medication Trials/Contraindications" section on first page)* □ A 3-month trial of topical clindamycin □ An adequate trial of ONE systemic antibiotic (e.g., doxycycline, minocycline, or tetracycline; clindamycin; clindamycin and rifampin; rifampin and moxifloxacin and metronidazole; rifampin and levofloxacin and metronidazole; amoxicillin/clavulanate)
□ **Yes** □ **No**	**Is the patient a candidate for or has a history of surgical intervention for hidradenitis suppurativa?**
MODERATELY-TO-SEVERELY ACTIVE RHEUMATOID ARTHRITIS	
□ **Yes** □ **No**	**Does the patient have a history of therapeutic failure of a 3-month trial of a conventional non-biologic disease-modifying antirheumatic drug (DMARD) in accordance with current consensus guidelines [e.g., American College of Rheumatology (ACR), European League Against Rheumatism (EULAR)]?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)*
□ **Yes** □ **No**	**Does the patient have a contraindication or an intolerance to conventional non-biologic DMARDs?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)*
NON-INFECTIOUS UVEITIS	
□ **Yes** □ **No**	**Does the patient have a diagnosis of uveitis associated with juvenile idiopathic arthritis or Behçet's syndrome?**
□ **Yes** □ **No**	**Does the patient have a history of therapeutic failure of or a contraindication, or an intolerance to any of the following?** *(If yes, check which applies and complete "Previous Medication Trials/Contraindications" section on first page)* □ A conventional systemic immunosuppressive (e.g., azathioprine, cyclophosphamide, cyclosporine, methotrexate, mycophenolate, tacrolimus) □ Systemic, topical, intraocular, or periocular corticosteroid
□ **Yes** □ **No**	**Does the patient have corticosteroid-dependent uveitis (defined as requiring a daily systemic corticosteroid dose equivalent to 7.5 mg or greater of prednisone in adults for six weeks or longer)?**
□ **Yes** □ **No**	**Will the patient be using the requested Cytokine and CAM Antagonist with the intent of discontinuing or decreasing the dose of the systemic corticosteroid?**
SARCOIDOSIS	
□ **Yes** □ **No**	**Does the patient have a history of therapeutic failure of or a contraindication or an intolerance to systemic glucocorticoids?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)*
□ **Yes** □ **No**	**Does the patient have glucocorticoid-dependent sarcoidosis?**
□ **Yes** □ **No**	**Does the patient have a history of therapeutic failure of or a contraindication or an intolerance to a conventional non-biologic DMARD?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)*
ULCERATIVE COLITIS – continued on next page	
□ **Yes** □ **No**	**Does the patient have a diagnosis of mild ulcerative colitis that is associated with multiple poor prognostic factors (examples include: initial diagnosis or clinical evidence supports the onset of symptoms at < 40 years of age, extensive colitis, severe endoscopic disease (presence of large and/or deep ulcers), hospitalization for colitis, elevated inflammatory markers, low serum albumin, and extra-intestinal manifestations, early need for corticosteroids)?**
□ **Yes** □ **No**	**Does the patient have a diagnosis of moderate-to-severe ulcerative colitis?**
□ **Yes** □ **No**	**Has the patient failed to achieve remission with or has a contraindication or intolerance to an induction course of corticosteroids?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)*

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ULCERATIVE COLITIS – continued from previous page	
□ Yes □ No	**Has the patient failed to maintain remission with an immunomodulator in accordance with current consensus guidelines (e.g., American College of Gastroenterology [ACG], American Gastroenterological Association [AGA], Canadian Association of Gastroenterology [CAG], European Crohn's and Colitis Organization [ECCO])?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)*
□ Yes □ No	**Does the patient have a contraindication or an intolerance to immunomodulators in accordance with current consensus guidelines (e.g., American College of Gastroenterology [ACG], American Gastroenterological Association [AGA], Canadian Association of Gastroenterology [CAG], European Crohn's and Colitis Organization [ECCO])?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)*
□ Yes □ No	**Has the patient achieved remission with the requested Cytokine and CAM antagonist?**
□ Yes □ No	**Will the patient be using the requested medication as maintenance therapy to maintain remission?**
ALL CONTINUATION OF THERAPY REQUESTS	
□ Yes □ No	**Has the patient experienced improvement in disease activity and or level of functioning since initiating therapy with the requested Cytokine and CAM Antagonist?**
□ Yes □ No □ Not applicable	**If no to the above question, is the patient prescribed an increased dose or more frequent administration of the requested Cytokine and CAM Antagonist that is supported by peer-reviewed medical literature or national treatment guidelines?**
□ Yes □ No	**Is the requested medication prescribed by, or in consultation with, an appropriate specialist (e.g., gastroenterologist, dermatologist, rheumatologist, ophthalmologist, immunologist, genetic specialist, pulmonologist, oncologist, etc.)?**
□ Yes □ No □ Not applicable	**For a Cytokine and CAM Antagonist associated with behavioral and/or mood changes as stated in the FDA-approved package labeling, was the patient recently reevaluated for behavioral and mood changes as recommended in the FDA-approved package labeling?**

Provider Signature: _____ **Date:** _____