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:
	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

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, sulfasalzine, 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:
  - ☐ Abatacept, infliximab: Six years of age or older
  - ☐ All others: 18 years of age or older.
- ☐ The recipient has failed to adequately respond to conventional therapy (e.g. sulfasalzine, mesalamine, antibiotics, corticosteroids, azathioprine, 6-mercaptopurine, leflunomide)
- ☐ The recipient has fistulizing Crohn's Disease

Ulcerative Colitis:

- ☐ The recipient has a diagnosis of moderate to severe ulcerative colitis
- ☐ The recipient is at an appropriate age, based on the requested agent:
  - ☐ 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 Autoinflamatory 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

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.