FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR RHEUMATOID ARTHRITIS (RA), JUVENILE IDIOPATHIC ARTHRITIS (JIA), AND PSORIATIC ARTHRITIS

INSTRUCTIONS: Type or print clearly. Before completing this form, read the Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Rheumatoid Arthritis (RA), Juvenile Idiopathic Arthritis (JIA), and Psoriatic Arthritis Instructions, F-01951A. Providers may refer to the Forms page of the ForwardHealth Portal at https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Publications/ForwardHealthCommunications.aspx?panel=Forms for the completion instructions.

Pharmacy providers are required to have a completed Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for RA, JIA, and Psoriatic Arthritis form signed by the prescriber before submitting a prior authorization request on the Portal, by fax, or by mail. Providers may call Provider Services at 800-947-9627 with questions.

SECTION I – MEMBER INFORMATION

1. Name – Member (Last, First, Middle Initial)

2. Member ID Number	3. Date of Birth – Member

SECTION II – PRESCRIPTION INFORMATION

4. Drug Name	5. Drug Strength
6. Date Prescription Written	7. Directions for Use

8. Name – Prescriber	9. National Provider Identifier – Prescriber

10. Address – Prescriber (Street, City, State, Zip+4 Code)

11. Phone Number – Prescriber

SECTION III – CLINICAL INFORMATION FOR RA, JIA, AND PSORIATIC ARTHRITIS (Required for all requests.)

12. Diagnosis Code and Description

Note: A copy of the member's medical records must be submitted with the prior authorization request to support the condition being treated, provide details regarding previous medication use, and outline the member's current treatment plan.

13. Check the box(es) to identify which condition(s) the member has.

1. ❑ RA
2. ❑ JIA
3. ❑ Systemic JIA
4. ❑ Psoriatic arthritis without axial symptoms
5. ❑ Psoriatic arthritis with axial symptoms

14. Is the prescription written by a rheumatologist or through a rheumatology consultation? ❑ Yes ❑ No

15. Is the member currently using the requested cytokine and CAM antagonist drug? ❑ Yes ❑ No

If yes, indicate the approximate date therapy was started.

16. Has the member attempted any of the following drugs for RA, JIA, or psoriatic arthritis: azathioprine, hydroxychloroquine, leflunomide, methotrexate, or sulfasalazine? ❑ Yes ❑ No

If yes, indicate the drug name(s), dose, specific details about the treatment response, and the approximate dates each drug was taken in the space provided. If additional space is needed, continue documentation in Section V of this form.

17. Has the member attempted other drugs for RA, JIA, or psoriatic arthritis (for example, nonsteroidal anti-inflammatory drugs, glucocorticoids, or IV immunomodulators such as infliximab)? ❑ Yes ❑ No

If yes, indicate the drug name(s), dose, specific details about the treatment response, and the approximate dates each drug was taken in the space provided. If additional space is needed, continue documentation in Section V of this form.

18. Indicate the cytokine and CAM antagonist drugs the member has taken and provide specific details regarding the treatment response. If additional space is needed, continue documentation in Section V of this form.

1. Drug Name _____ Dose _____ Dates Taken _____

Reason for Discontinuation _____

2. Drug Name _____ Dose _____ Dates Taken _____

Reason for Discontinuation _____

3. Drug Name _____ Dose _____ Dates Taken _____

Reason for Discontinuation _____

19. Indicate the clinical reason(s) why the prescriber is requesting a non-preferred cytokine and CAM antagonist drug.

SECTION III A – ADDITIONAL CLINICAL INFORMATION FOR SIMPONI REQUESTS

20. Will the member continue to take methotrexate in combination with Simponi? ❑ Yes ❑ No

SECTION III B – ADDITIONAL CLINICAL INFORMATION FOR XELJANZ XR REQUESTS

21. Prior authorization requests for Xeljanz XR must include detailed clinical justification for prescribing Xeljanz XR instead of Xeljanz. This clinical information must document why the member cannot use Xeljanz, including why it is medically necessary that the member receive Xeljanz XR instead of Xeljanz.

SECTION IV – AUTHORIZED SIGNATURE

22. **SIGNATURE** – Prescriber	23. Date Signed

SECTION V – ADDITIONAL INFORMATION

24. Include any additional information in the space below. Additional diagnostic and clinical information explaining the need for the product requested may be included here.

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