

Prior Authorization (PA) Form
Cytokine and CAM Antagonists and Related Agents

If the following information is not complete, correct, or legible, the PA process can be delayed.

Please use one form per member.

MEMBER INFORMATION

Last Name:

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First Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Medicaid ID Number:

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Date of Birth:

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Gender: Male Female

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name:

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First Name:

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NPI Number:

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Phone Number:

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Fax Number:

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DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

Preferred drugs Enbrel® or Humira® do not require a PA.

All Non-Preferred drugs listed below require a PA:

- | | | | | |
|-----------------------------------|-----------------------------------|------------------------------------|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Actemra® | <input type="checkbox"/> Cimzia® | <input type="checkbox"/> Cosentyx™ | <input type="checkbox"/> Dupixent® | <input type="checkbox"/> Entyvio® |
| <input type="checkbox"/> Ilaris® | <input type="checkbox"/> Ilumya™ | <input type="checkbox"/> Kevzara® | <input type="checkbox"/> Kineret® | <input type="checkbox"/> Olumiant® |
| <input type="checkbox"/> Orencia® | <input type="checkbox"/> Otezla® | <input type="checkbox"/> Otrexup® | <input type="checkbox"/> Rasuvo™ | <input type="checkbox"/> Remicade® |
| <input type="checkbox"/> Siliq® | <input type="checkbox"/> Simponi® | <input type="checkbox"/> Skyrizi® | <input type="checkbox"/> Stelara® | <input type="checkbox"/> Taltz® |
| <input type="checkbox"/> Tremfya™ | <input type="checkbox"/> Trexall® | <input type="checkbox"/> Xatmep™ | <input type="checkbox"/> Xeljanz® | <input type="checkbox"/> Xeljanz® XR |

(Form continued on next page.)

<https://medproviders.anthem.com/va>

Cytokine and CAM Antagonists and Related Agents

Member's Last Name:

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Member's First Name:

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DIAGNOSIS AND MEDICAL INFORMATION

Does the member meet the following criteria?

1. Diagnosis (check all that apply):

- Rheumatoid Arthritis (RA) Polyarticular juvenile idiopathic arthritis (pJIA)
- Juvenile Idiopathic Arthritis (JIA) Adult Crohn's disease (CD) Pediatric Crohn's Disease
- Ankylosing Spondylitis (AS) Psoriatic arthritis (PsA) Hidradenitis Suppurativa (HS)
- Plaque Psoriasis (PsO) Ulcerative Colitis (UC) Uveitis (UV)
- Disease is classified as moderate to severe
- Diagnosis not listed above: _____

2. Therapeutic failure to oral methotrexate

- Yes No N/A

3. Therapeutic failure to one of the preferred agents:

- Yes No

Please give details of failure below:

4. Medical Necessity: Provide clinical evidence that supports the use of the requested medication.

Prescriber Signature (Required)

Date

By signature, the Physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the PA process.

Submission of documentation does NOT guarantee coverage.

The completed form may be: **FAXED TO 1-844-512-7020.**