https://providers.amerigroup.com

Biologicals for Arthritis Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-512-9004.
Provider Help Desk: 1-800-454-3730

1. Patient information	**2. Physician information**
Patient name:_____	Prescribing physician:_____
Patient ID #: _____	Physician address: _____
Patient DOB:_____	Physician phone #: _____
Date of Rx: _____	Physician fax #:_____
Patient phone #:_____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
_____	_____	_____	Specify: _____

7. Diagnosis:_____

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

Prior authorization is required for biologicals used for arthritis. Request must adhere to all FDA approved labeling. Payment for nonpreferred biologicals for arthritis will be considered only for cases in which there is documentation of previous trials and therapy failures with two preferred biological agents. Payment will be considered under the following conditions:

1. Patient has been 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; and
2. Patient has been screened for hepatitis B and C. Patients with evidence of active hepatitis B infection (hepatitis surface antigen positive > six months) must have documentation they are receiving or have received effective antiviral treatment.

In addition to the above, requests for TNF Inhibitors:

1. Patient has not been treated for solid malignancies, nonmelanoma skin cancer, or lymphoproliferative malignancy within the last five years of starting or resuming treatment with a biological agent; and
2. Patient does not have a diagnosis of congestive heart failure (CHF) that is New York Heart Association (NYHA) class III or IV and with an ejection fraction of 50 percent or less.

Requests for Interleukins: Medication will not be given concurrently with live vaccines.

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Preferred	Nonpreferred		
☐ Cosentyx (after Humira trial)	☐ Actemra	☐ Kevzara	☐ Simponi
☐ Enbrel	☐ Cimzia (prefilled syringe)	☐ Kineret	☐ Stelarai
☐ Humira	☐ Ilaris	☐ Orencia	☐ Taltz

Screening for Hepatitis B — Date: _____ Active disease: ☐ Yes ☐ No
Screening for Hepatitis C — Date: _____ Active disease: ☐ Yes ☐ No
Screening for latent TB infection — Date: _____ Results: _____

Requests for TNF inhibitors:
Has patient received treatment for solid malignancies, nonmelanoma skin cancer or lymphoproliferative malignancy within last five 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

Requests for interleukins:
Will medication be given concurrently with live vaccines? ☐ Yes ☐ No

☐ **Rheumatoid arthritis (RA)** (Humira, Enbrel, Actemra, Cimzia, Kineret, Orencia, Simponi, Kevzara)
Payment will be considered upon a trial and inadequate response to two preferred disease modifying antirheumatic drugs (DMARD) used concurrently. The combination must include methotrexate plus another preferred oral DMARD (hydroxychoroquine, sulfasalazine, or leflunomide). Upon an unsuccessful methotrexate trial in patients with established RA, the combination trial with a second DMARD may be overridden if there is evidence of severe disease documented by radiographic erosions.

Methotrexate trial
Dose: _____ Trial dates: _____
Failure reason: _____

Plus preferred oral DMARD trial
Drug name and dose: _____ Trial dates: _____
Failure reason: _____
Radiographic evidence indicating erosions: ☐ Yes ☐ No

☐ **Psoriatic arthritis, moderate to severe** (Cimzia, Cosentyx, Enbrel, Humira, Simponi, Stelara, Taltz)
Payment will be considered upon a trial and inadequate response to the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated).

Methotrexate or preferred oral DMARD trial
Drug name and dose: _____ Trial dates: _____
Failure reason: _____
Methotrexate contraindication if applicable: _____

☐ **Juvenile idiopathic arthritis, moderate to severe** (Enbrel, Humira, Actemra, Orencia, Ilaris)
Payment will be considered upon a trial and inadequate response to intraarticular glucocorticoid injections and the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated).

Intraarticular glucocorticoid injections
Drug name and dose: _____ Trial dates: _____
Failure reason: _____

Plus methotrexate or preferred oral DMARD trial

Drug name and dose: _____ Trial dates: _____
Failure reason: _____
Methotrexate contraindication if applicable: _____
Reason for use of nonpreferred drug requiring prior approval: _____
_____

Other medical conditions to consider: _____

Attach lab results and other documentation as necessary.

9. Physician signature

_____ _____

Prescriber or authorized signature Date

Prior authorization of benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.