# *Biologicals for Axial Spondyloarthritis*
# *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 axial spondyloarthritis conditions. Payment will be considered under the following conditions:

1) Patient has a diagnosis of ankylosing spondylitis (AS) or nonradiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation; and
2) The requested dose does not exceeed the maximum FDA labeled or compendia recommended dose for the submitted diagnosis; and
3) Patient has been screened for hepatitis B and C, patients with active hepatitis B will not be considered for coverage; and
4) 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
5) Patient has documentation of an inadequate response to at least two preferred non- steroidal anti-inflammatories (NSAIDs) at maximum therapeutic doses, unless there are documented adverse responses or contraindications to NSAID use. These trials should be at least one month in duration: and
6) Patients with symptoms of peripheral arthritis must also have failed a 30-day treatment trial with at least one conventional disease modifying antirheumatic drug (DMARD), unless there is a documented adverse response or contraindication to DMARD use. DMARDs include sulfasalazine and methotrexate; and
7) Requests for non- preferred biologicals for axial spondyloarthritis conditions will be considered only for cases in which there is documentation of previous trials and therapy failures with two preferred biological agents that are FDA approved or compendia indicated for the submitted diagnosis, when applicable.

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 5 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% 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) | ☐ Cimzia |
| ☐ Humira | ☐ Simponi |
| ☐ Enbrel | |

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

**NSAID trial #1**
Name/dose: _____
Trial start date: _____
Trial end date: _____
Reason for failure: _____

**NSAID trial #2**
Name/dose: _____
Trial start date: _____
Trial end date: _____
Reason for failure: _____

**DMARD trial** (for peripheral arthritis diagnosis)
Name/dose: _____
Trial start date: _____
Trial end date: _____
Reason for failure: _____

**Requests for TNF Inhibitors:**
Has patient received treatment for solid malignancies, nonmelanoma skin cancer, or lymphoproliferative malignancy within last 5 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
Reason for use of nonpreferred drug requiring prior approval: _____
_____
Other medical conditions to consider: _____
Possible drug interactions/conflicting drug therapies: _____

**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.