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Biologicals Inflammatory Bowel Disease 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 inflammatory bowel disease. Request must adhere to all FDA-approved labeling. Payment for non-preferred biologicals for inflammatory bowel disease will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered under the following conditions:

1) Patient has been screened for hepatitis B and C, patients with active hepatitis B will not be considered for coverage
2) 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.

In addition to the above, requests for TNF Inhibitors will be considered under the following conditions:

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;
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**	
☐ Humira	☐ Cimzia (prefilled syringe)	☐ Stelara
☐ Humira Starter Kit	☐ Simponi	

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 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

☐ **Crohn's Disease**
Payment will be considered following an inadequate response to two preferred conventional therapies including aminosalicylates (mesalamine, sulfasalazine), azathioprine/6- mercaptopurine, and/or methotrexate.

Trial drug name/dose: _____ Trial dates: _____
Failure reason: _____
Trial drug name/dose: _____ Trial dates: _____
Failure reason: _____
Reason for use of nonpreferred drug requiring prior approval: _____

☐ **Ulcerative colitis (moderate to severe)**
Payment will be considered following an inadequate response to two preferred conventional therapies including aminosalicylates and azathioprine/6-mercaptopurine.

Trial drug name/dose: _____ Trial dates: _____
Failure reason: _____
Trial drug name/dose: _____ Trial dates: _____
Failure reason: _____
Reason for use of nonpreferred drug requiring prior approval: _____
Possible drug interactions/conflicting drug therapies/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.